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ABSTRACT

This guide for educators, human service workers, and others interested in social gerontology contains four sections covering fifteen subject areas/sessions. Unit 1, Societal Structure and Its Relationship to the Aged, presents data concerning demographics of the aging population, historical factors having an impact upon value processing of older adults, changing roles in families, and an overview of gerontology program resources. Unit 2, Gerontological Mental Health, provides information regarding selected life events/stress factors in the aging cycle, including emotional adjustments to cope with death and aging, recognition and management of grief, creative use of leisure, and impact of ageism. Unit 3, Physical Aspects of Aging, reviews the biological basis and physical changes and their implications, including special factors involving the ecosystem of environmental impact and drug use and misuse. Unit 4, Cultural Values and Their Impact on Older Kansans, discusses ethnic experiences and cultural values as related to needs, concerns, and resources of specific elderly groups with examples of cultural heritage and unique problems of service delivery and programming objectives for Spanish speaking, Indian, and Mid-western rural elderly. For each session these materials are provided: sample agendas, training objectives, condensed lectures, group exercises/discussions, examples of audiovisual aids, and bibliography. (YLB)

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SOCIAL GERONTOLOGY

TRAINING MANUAL

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Social Gerontology Training Project

Sponsored by:

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Preface

Much about human aging and the social forces in later life is not known, but infinitely more is know than is applied. This manual is designed to be used as a guide for educators, human service workers and all those who are interested in social gerontology. Fifteen workshops in four topical areas of social gerontology were conducted to pre-test materials and utilize diverse resources. The news articles and reprints were current at the time of the workshops and are uses as examples of the growing daily interest in social gerontology. In the dynamics of the developing discipline of gerontology, materials are sometimes outdated before they are printed. Hopefully the information included in this manual can be used as springboards to further explore ageism, aging and the society.

The manual is divided into four sections, briefly described as follows:

Societal Structure and its Relationship to the Aged
Data concerning the demographics of the aging population, historical factors that impact upon the value processing of older adults, the changing roles in families and a brief overview of the panorama of gerontology program resources.

Gerontological Mental Health
Information relevant to selected life events or stress factors involved in the aging cycle including the emotional adjustments necessary to cope with death and aging, recognition and management of grief, creative use of leisure and the impact of ageism.

Physical Aspects of Aging
A cursory review of the biological basis for the aging process and the physical changes and their implications with special factors involving the ecosystem of environmental impact and the use and misuse of drugs in later life included.

Cultural Values and Their Impact on Older Kansans
Materials about ethnic experiences and cultural values as related to needs, concerns and resources of specific elderly groups with examples of cultural heritage and unique problems of service delivery and programming objectives for Spanish speaking, Indian and Mid-western rural elderly.

Sample agendas, training objectives, condensed lectures, examples of audio-visual aides and bibliographies are given for fifteen subject areas. Resource materials are presented in printed form in this manual.

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Societal Structure and Aging

SOCIAL GERONTOLOGY

UNIT #1
SOCIETAL STRUCTURE AND ITS RELATIONSHIP TO THE AGED (CS 311)

SESSION #1
THE DEMOGRAPHY OF THE AGED (CS 311-A)

Resource leader: Jeanne C. Tucker, Director
Gerontology Institute, Washburn University of Topeka

Suggested Agenda

Introductory lecture:	Why be concerned with the demography of the aged?
Illustrated lecture:	Where are the aged in Kansas?
Group discussion:	Who are the aged?
Group exercise:	What are specific demographic answers and where do we find them regarding the demography of the aged?

Feedback and evaluation

Objectives of session #1

1. Present current factual knowledge regarding the distribution of basic demographic characteristics among the older population in general.

2. Present facts regarding the distribution of basic demographic characteristics regarding age range, sex, marital status, residential arrangement, income, and geographic distribution.

3. Discuss general statistics concerned with the distribution of basic demographic characteristics around the world, in the United States, and in Kansas.

4. Offer opportunities to find and utilize basic literature regarding basic demographic characteristics.

5. Have available materials that would allow the participant to find relevant local, regional, and national data on aging demographic characteristics.

6. Discuss the impact of the future 65+ population bulge.

7. Discuss the need for hesitancy in formulating simplisitic problem analysis and problem-solving approaches to gerontological issues.

8. Discuss the need for a basic understanding of societal structure in relationship to gerontological issues.

9. Discuss the need to constructively cope with and solve the problems of the aged and by so doing, of people of all ages.

Introductory Lecture

Why be Concerned with the Demography of the Aged

Interest in social gerontology is currently high. Federal, state and local governments are creating special departments devoted to aging concerns. For most of the history of the United States, Americans have thought of themselves as youthful - but that profile is changing. Increasing numbers of people are reaching old age because of improved health services, better working conditions and a host of other reasons.

This graying of America is already perceptible. Politicians feel increasing pressure from their elderly constituents. Organizations such as the Gray Panthers receive front page coverage as they work to dispel aging myths and stereotypes. Business and industries have altered their advertising and their products to reach this increasing mature audience.

Demographic change is by nature an evolutionary process and the adjustments are taking place slowly. National statistics indicate this changing profile and everyone seems to be involved in new surveys, census collections and needs assessments to analyze potential problems and plan for future solutions. Perhaps one of the most clear cut question posed by this demographic change is an economic one. How will a decreasing percentage of the population who are in the work force bear the cost of caring for the increasing percentage of the 65+ or retired populations?

Life expectancy figures from all over the world are changing and impacting on society. Undeveloped countries are joining industralized countries in rising percentages of 65+ population. Population figures from the United States indicate one out of every ten with over twenty million 65+ individuals living in just ten states. (Handout #1)

An article called "The Graying of America" from Newsweek, February 28, 1977, illustrates this changing profile. (Handout #2)

Social gerontologist need to be aware of statistical reports -- but they also need to be aware of some of the disadvantages of responding only to numbers. Sometimes there are hidden factors that need to be explored. By participating in a group exercise or census collection perhaps some of the subtle and varied problems of data collection might be explored.

We need to be aware of two factors that we will have as we compile the data that many data collection processes do not have. One, we are a small group and we can visually count the number in our group and compare the count with the responses. Two, a clarification dialogue is possible - for you to clearly understand what data was needed and for the census taker to verbally ask for additional data. We know that many times this is not the case.

1

Table 3.2 Life expectancy at birth, by sex and population—age 65 and over for various countries and years

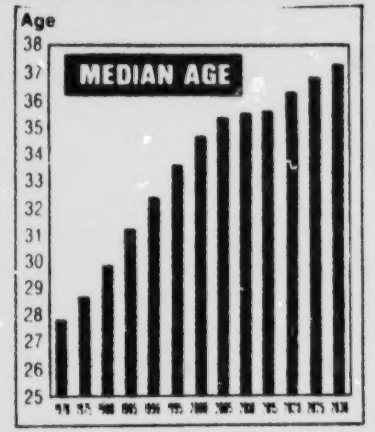
Country	Year	Life expectancy at birth		Population age 65 and over	
		Male	Female	Number (in thousands)	Percent of total
North America					
United States	1970	67	75	20,101	9.9
Canada	1971	68.8	75.2	1,744	8.1
Haiti	1972 (est.)	—44.5—		157	3.1
Mexico	1970	61.0	63.7	1,791	3.7
South America					
Argentina	1972 (est.)	64.1	70.2	1,805	7.5
Brazil	1970	—60.7—		4,760	5.1 (age 60+)
Venezuela	1970 (est.)	—63.8—		252	2.4
Asia					
China	1970 (est.)	—50.0—		—	—
Japan	1970	69.1	74.3	7,330	7.1
Iran	1971 (est.)	—50.0—		940	3.1
Syria	1970 (est.)	—52.8—		193	3.2
USSR	1970	65.0	74.0	28,514	11.8
Europe					
Austria	1970	66.6	73.7	1,047	14.2
Denmark	1969	70.8	75.7	590	12.1
France	1968	68.6	76.1	6,662	13.4
Hungary	1970	66.3	72.0	1,178	11.4
Netherlands	1971 (est.)	71.0	76.7	1,353	10.3
Sweden	1970	71.7	76.5	1,109	13.7
United Kingdom	1971	68.8	75.1	6,397	13.1
Africa					
Ethiopia	1968 (est.)	—38.5—		2,811	11.9 (age 45+)
Ghana	1970	—46.0—		311	3.6
Kenya	1969	46.9	51.2	391	3.6
S. Africa	1970	—49.0—		870	4.1
Uganda	1969	—47.5—		365	3.8
Zambia	1970	—43.5—		135	4.0 (age 60+)

SOURCE: United Nations, *Demographic Yearbook: 1972* (New York: United Nations), Tables 3 and 6 (1973). Reproduced by permission.

Table 3.11 Population age 65 and over: ten leading states in the United States: 1970

Rank	State	Number	Percent increase since 1960	Percent of state total in 1970
1	New York	1,961,000	16.2	10.8
2	California	1,801,000	30.9	9.0
3	Pennsylvania	1,272,000	12.7	10.8
4	Illinois	1,094,000	12.2	9.8
5	Ohio	998,000	11.2	9.4
6	Texas	992,000	33.1	8.9
7	Florida	989,000	78.9	14.6
8	Michigan	753,000	18.0	8.5
9	New Jersey	697,000	24.4	9.7
10	Massachusetts	636,000	11.3	11.2
	United States	20,177,000	21.0	9.9

SOURCE: Adapted from United States Bureau of the Census, *Census of Population: 1970, General Population Characteristics*, (Washington, D.C.: United States Government Printing Office) Final Report, PC (1)-B1, Tables 59 and 62; *Census of Population: 1960, Characteristics of the Population, Volume I*, Part 1 (Washington, D.C.: United States Government Printing Office) United States Summary, Tables 55 and 59.



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A CHANGING PROFILE

D

Table 3.2 Population age 65 and over in the United States, for each decennial year with projections to 2020: 1900-2020

Year	Population age 65 and over: Number (in thousands)	Population age 65 and over: Percent of total population	Percent increase from preceding decade: Age 65 and over	Percent increase from preceding decade: Total population
1900	3,099	4.1	—	—
1910	3,986	4.3	28.6	21.0
1920	4,929	4.7	23.7	14.9
1930	6,705	5.4	36.0	16.1
1940	9,031	6.8	34.7	7.3
1950	12,397	8.2	37.3	14.5
1960	16,679	9.2	34.5	18.5
1970	20,177	9.9	21.0	13.3
Projections:		Series B[b] Series E[b]		Series B[b] Series E[b]
1980	24,051[a]	10.2 10.6	19.2	15.6 11.2
1990	27,768[a]	10.0 11.0	15.5	17.7 10.4
2000	28,842[a]	8.9 10.6	3.9	15.7 7.8
2010	30,940	8.1 10.6	7.3	18.3 7.2
2020	40,261	9.1 13.1	30.1	17.3 5.7

[a]Revised data from United States Bureau of the Census. *Current Population Reports*, Series P-25, No. 493, "Projections of the Population of the United States, by Age and Sex: 1972-2020" (December 1972).

[b]Assumptions of completed fertility (average number of births per woman upon completion of childbearing years):
Series B: 3.10 (high-fertility assumption).
Series E: 2.10 (low-fertility assumption, which mirrors present replacement level trend in the United States).

SOURCE: United States Bureau of the Census *Current Population Reports*, Series P-25, No. 470, "Projections of the Population of the United States, by Age and Sex: 1970-2020" (November 1971); Series P-25, No. 38, "Projections of the Population of the United States, by Age, Sex and Color to 1990, with Extensions of Population by Age and Sex to 2015"

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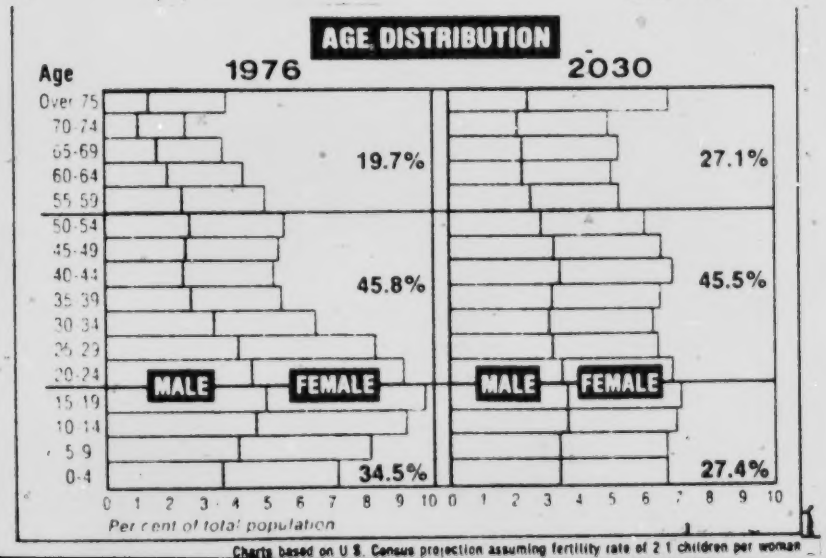


Charts based on U.S. Census projection assuming fertility rate of 2.1 children per woman

Introductory Lecture

Why Be Concerned with the Demography of the Aged

Preparation: Ten charts prepared and placed around the room. Participants fill in their own personal demographic data as they enter workshop.

Charts

1. Male _____ Female _____
2. Age
   - 0 - 21
   - 22 - 35
   - 36 - 45
   - 46 - 60
   - 61 - 65
   - 66 +
3. Education
   - High School_____
   - Some College_____
   - Baccalaureate_____
   - Some Graduate_____
   - Graduate or Professional _____
4. Birthday
   - January/February/March/April/May/June/July/August/September
   - October/November/December
   - Summer/Spring/Winter/Fall
5. Are Parents Living
   - Yes_____ No_____
   - How Many_____
   - Oldest_____
   - Youngest_____
6. Grandparents Living
   - Yes_____ No_____
   - How Many_____
   - Oldest_____
   - Youngest_____
   - Great Grandparents_____

7. Do You Have Children Yes_____ No_____

Number of Sons _____

Number of Brothers_____

Number of Sisters _____

8. Number of Brothers and Sisters in Your Family

Number of Brothers_____

Number of Sisters _____

9. Size of Community in Which You Were Born

0 - 1,000

1,001 - 5,000

5,001 - 10,000

10,001 - 100,000

100,001 - 500,000

1,000,000 +

10. Are You Wide Awake Yes_____ No_____

Do You Know More Than Five People in the Room Yes_____ No_____

Have You Ever Explored Demography Life Yes_____ No_____

Lecture

Objective:

1. To explore the variations and fallacies in securing and presenting demographic materials.

2. To present some demographic information.

3. To increase the awareness of the impact of demography upon the development of programs and services.

I Discussion of charts as they relate to demographic data

Male/Female:

1. Only two answers, but not sure of accuracy. Did everyone carry out the request to fill in all the charts? Some participants arrived late and may not have filled in all/or any of the information. As census takers gather information, even questions that are concise and clear cut may not be accurate because of some "invisible elderly."

Age:

2. The participant might be sensative about age and because others are observing the answer, they might lie. This exercise had no method for data verification, as often times survey and census data do not include methods of verification.

Education:

3. Because of the profile of the group, it would be likely that there would be a higher level of education shown. In demographic data, one needs to be aware of the sample, and the profile of that sample (i.e., ethnicity, geographic, religion preference, etc.)

Birthday:

4. A fairly complex question with twelve possible answers. Most were able to respond correctly to top part of question, but the area on bottom marked summer, spring, winter, fall. What did that mean? It needed verbal explanation to clarify the question. Some data is gathered with no verbal feedback and the participant might not be clear as to what the question seeks to ascertain.

Parents Living:

5. The participant might respond correctly, but by the time the information was processed, printed and disseminated, the age of the parent might have changed - or the parent might have died. Demography is dynamic - not static - and it is impossible to gather and disseminate accurate data.

Grandparents Living:

6. Many participants did have one/two or more grandparents and even great grandparents living. This demographic feature of our population indicates that we are finding more and more individuals in the "sandwich generation" - having adult children and parents/grandparents or four generation families.

Do You Have Children:

7. This demographic feature of this particular sample indicates the trend toward smaller families. Had the survey been conducted in 1900, the number of children per participant would probably have been double.

Number of Brothers and Sisters in Your Family:

8. Now? Ever? The question is unclear and the participant might have had three brothers and lost one - or through remarriage of their parents might have half-brothers or step-brothers - Demographers might find this type of inaccuracy by gathering data in New York in the fall and Florida in the spring - and survey the same person twice.

Size of Community:

9. The location of the sample taking "colored" this means average size of community. If same sample had been taken in New York City, the response would probably be quite different. We need to be aware that figures reflected in a nationwide basis and local basis are often quite different. The fact that Kansas has a high percentage of 65 + population does not reflect the number of 65 population. New York's percentage might be less, but the number is far greater.

Wide Awake:

10. Who is the judge of objective questions? the respondent or the census taker? Some data or attitudes and values are difficult to verify, although sometimes survey needs attempt to document attitudes.

Where are the Aged in Kansas

One of the common myths about the aging population is the misconception of where older people are. Responses to the questior "What percentage of the 65+ population are in nursing homes?" range from 75% to 20%. Statistical studies indicate that less than 5% of our 65+ population are institutionalized -- and that included prisons, adult care homes and mental hospitals.

Actually, we will find older people are in the community. But -- we need to check out our preception of community and see if we concur. Did a specific geographic place spring to your mind? Topeka, Olathe, Oakland? Communities begin with people who have needs they would like to satisfy. Let's explore a more abstract community concept with a defination offered by Robert Atchely on Social Forces in Later Life.

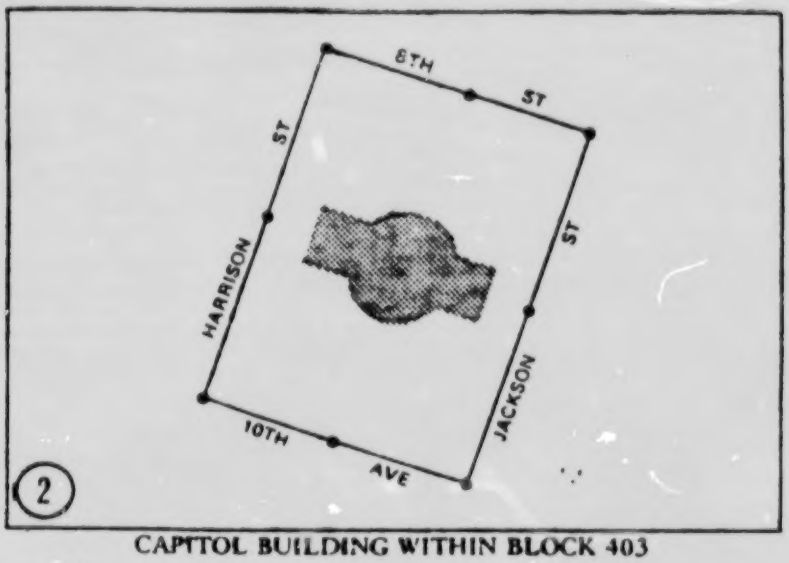
> "A community is a group of people who interact with one another frequently, who share their location in space, who depend on one another -- even indirectly -- to fill their needs and who share an identity with the place they live."

Illustration #1

KANSAS STATE CAPITOL BUILDING

By this definition we can identify the individuals that work together in the State Capitol as a community. They share certain ideas that are uniquely involved with Kansas government policies and decisions. Couldn't we identify them as a community of legislators? And we could identify many similar communities such as health care personnel in a hospital, Washburn University students, perhaps a group of participants in a senior citizen center.

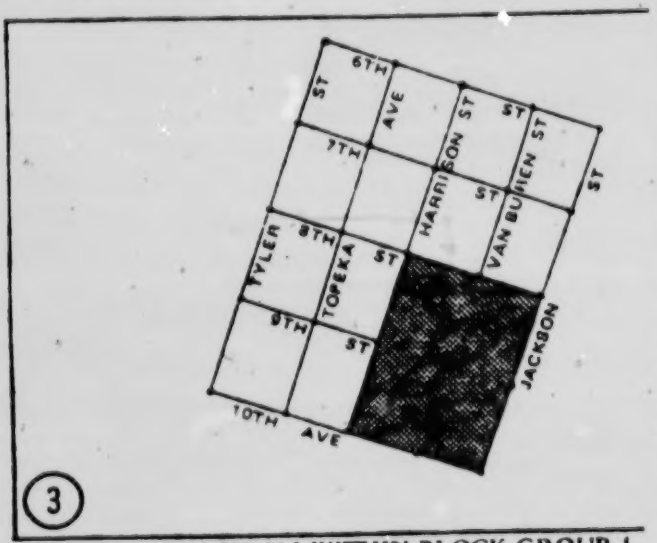
Illustration #2



CAPITOL BUILDING WITHIN BLOCK 403

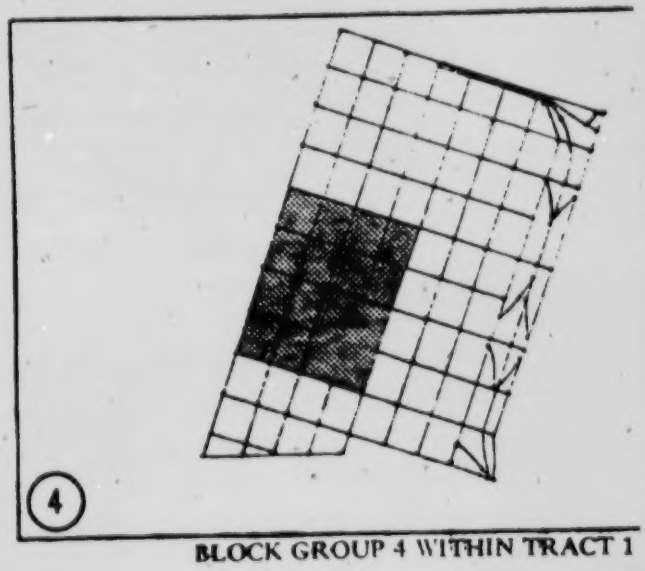
Geographic location and size are two other elements involved in defining community. There are many communities that can be identified in areas as small as the capitol grounds. Because of population density, ethnic characteristics - or age regulated housing - one can find many pocket size communities of shared cultural, economic and social interdependence. What about the elderly high rise communities in Topeka like Polk Plaza, Tyler Towers, Luther Place, Landmark Plaza, etc. - don't they have the necessary characteristics to be a community?

Illustration #3



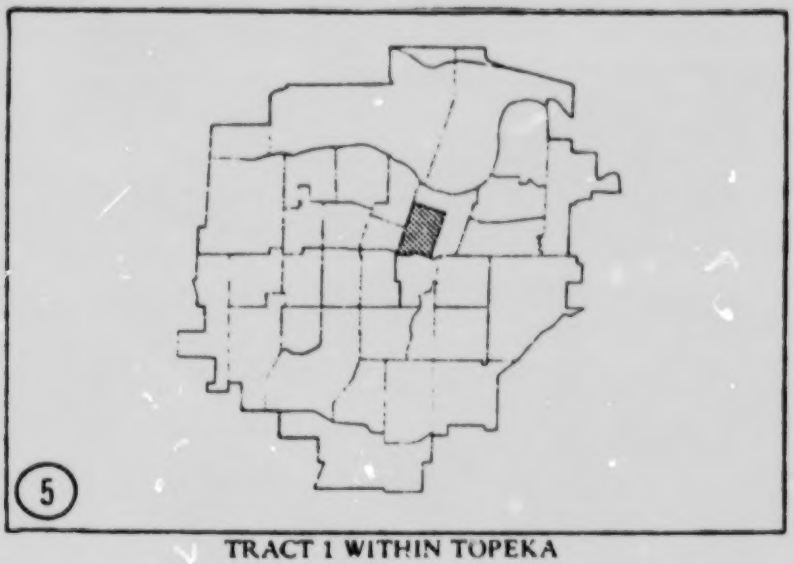
BLOCK 403 WITHIN BLOCK GROUP 4

Illustration #4



BLOCK GROUP 4 WITHIN TRACT 1

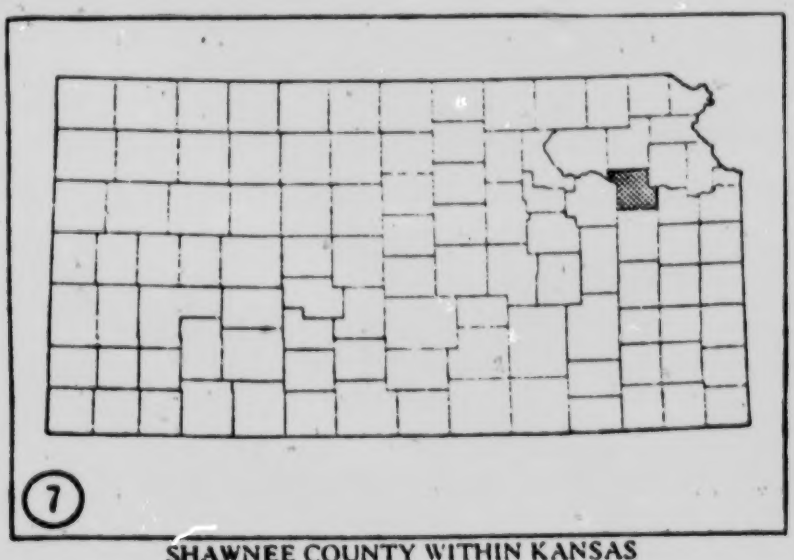
Neighborhoods, school districts, wards, retirement villages also might be identified as communities. Interpersonal communication occurs as individuals with similar objectives interact. They depend on one another to fill their needs and share an identity with the place they live. School District #501, Highland Park, Aldersgate Village all could be defined as communities as this interaction takes place.



TRACT 1 WITHIN TOPEKA

Our ideal concept of a community is a relatively autonomous locality with a population large enough to foster a social system, complete with social and economic institutions. We run into trouble as we try to define the "older community" because although they are a population large enough to foster a social system with social and economic institutions, they are everywhere-east side/west side, rich and poor.

Illustration #6



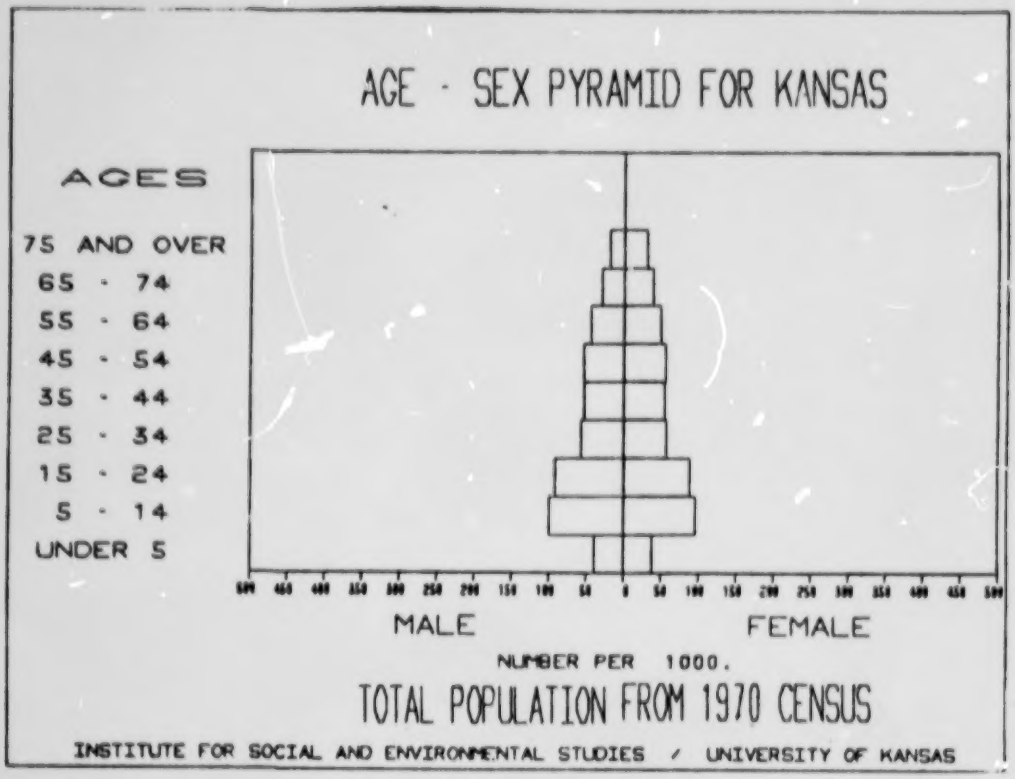
SHAWNEE COUNTY WITHIN KANSAS

The larger the size and density of a locality - or community - the harder it is to maintain the daily interaction, shared culture and social interdependence. The 12% of the Kansas population over 60+ or 397,830 people constitute a community too large to reach consensus on goals, objectives, desires, needs, concerns and perceived problems.

Illustration #7

KANSAS WITHIN THE U.S.

Communities in the larger sense can be defined as an important focal point in the lives of older people. People are born, reared, educated, married, housed, fed. healed, mourned and buried in a community. Older people are usually long term community residents and are likely to identify a community as the focus of life's most salient moments. Kansans may move to Sun City or Florida, but they may form a sub-community of mid-westerners to share common values and interests.

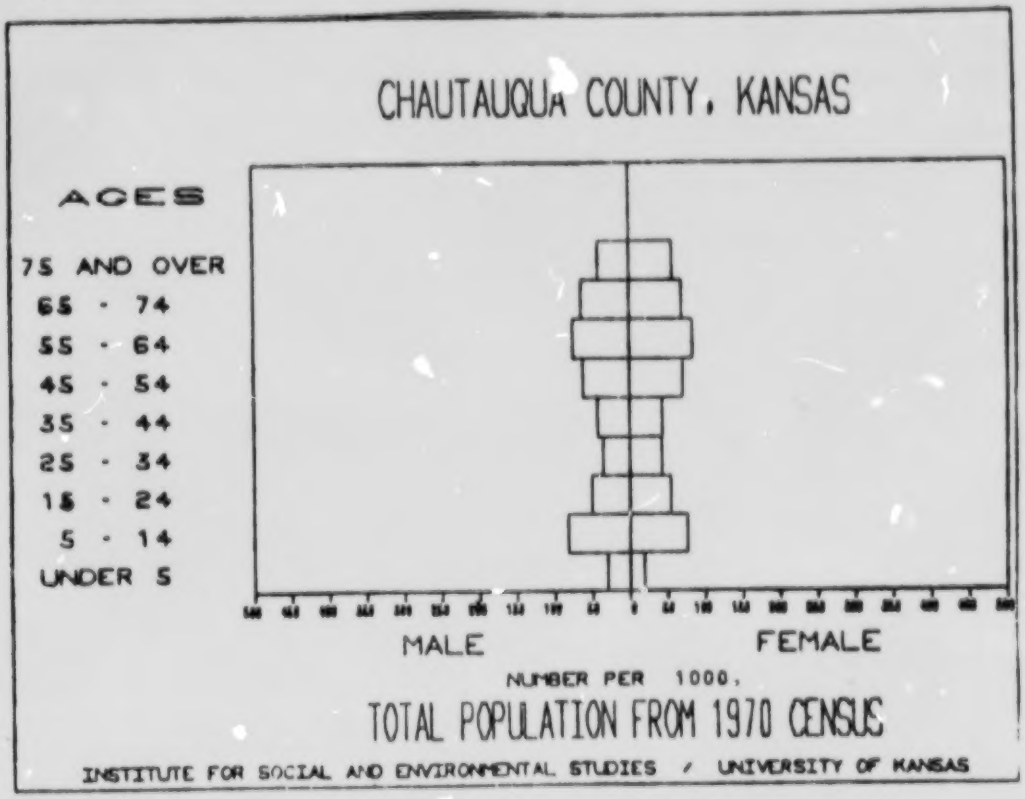


But where are the aged in Kansas? The 1970 census and unofficial enumerations indicate some fascinating pictures. One way to look at the population is the age - sex pyramid prepared by the Institute for Social and Environmental Studies University of Kansas.

Kansas has 105 counties and each county can be "pyramided" to graphically illustrate the population composition.

The State Age - Sex Pyramid looks something like a true pyramid - with a small birth rate, a solid base of young people five - twenty-four, and a good proportion of individuals in the age group twenty-five - sixty-four, or the traditional age of the work force.

Illustration #9



By studying this south east county pyramid, we find a distorted population structure with a definite increase in ages forty-five - seventy, and extreme constriction in the twenty-five - forty-five. The productive, working population is outnumbered by dependent children and potentially dependent older individuals. Also the birth rate is low - because of the higher proportion of people seventy-five and over.

Illustration #10

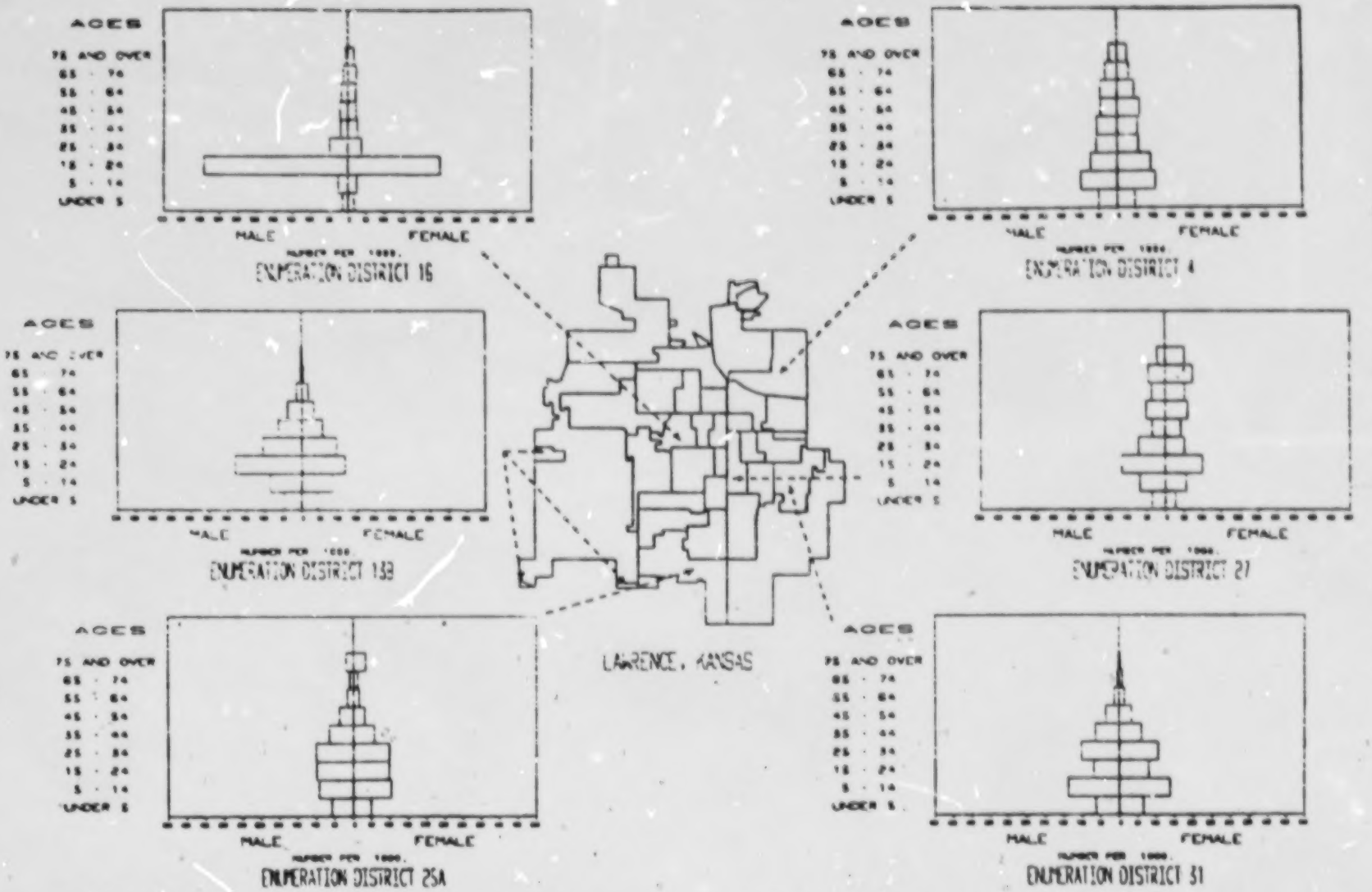
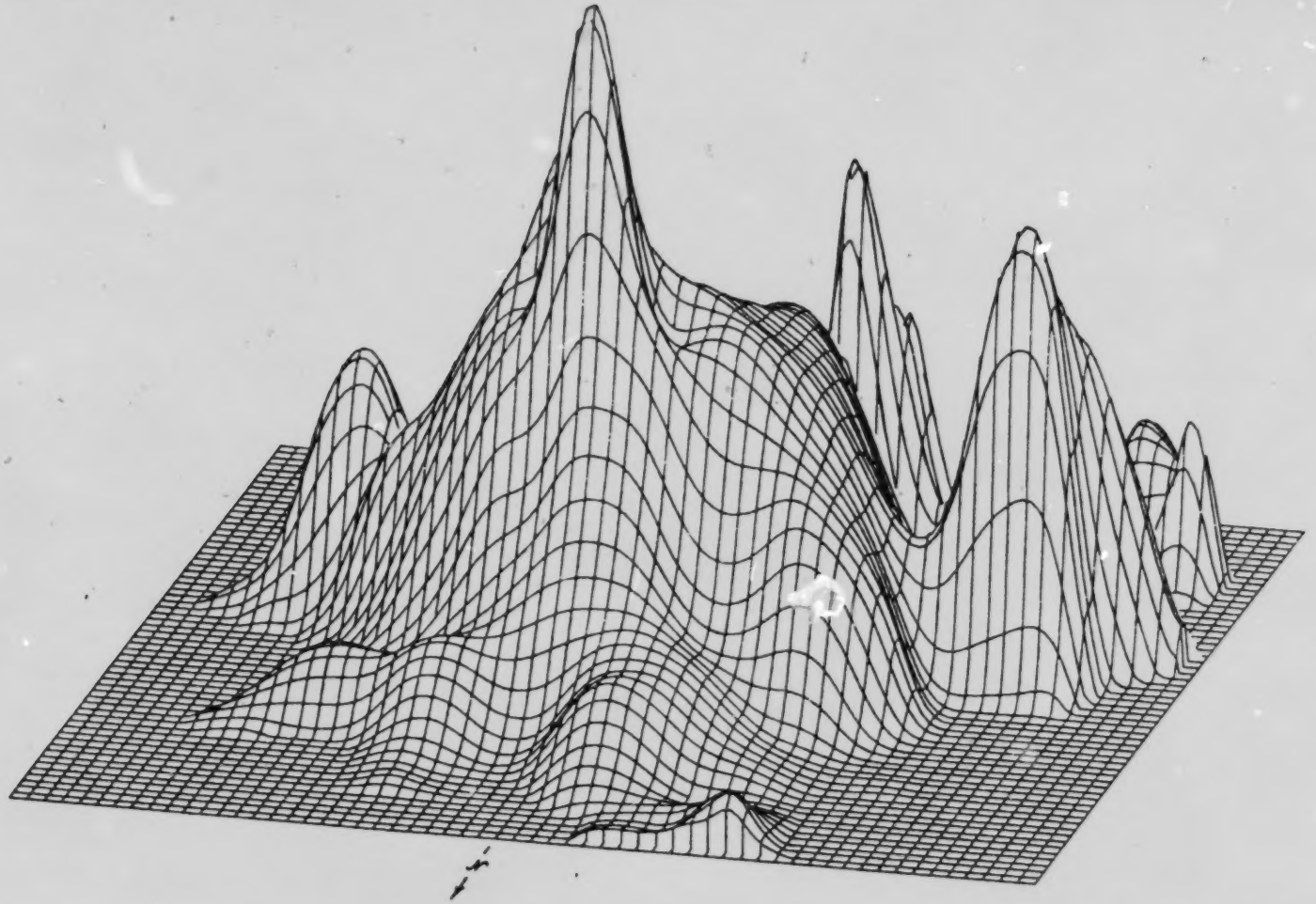


Figure 10. Pyramids for Selected ED's in Lawrence

By building these pyramids we can visualize the impact of specific demographic data. Planning for the older population can be more comprehensive. As we look at the pyramids for selected enumeration districts of Lawrence, we see characteristics of where age groups are to formulate long range plans that meet the need of the community.

Would we need a school or a high rise for the elderly in enumeration district #13B? #4? Do you suppose we could find Kansas University by the age - sex pyramid?

Illustration #11



POPULATION DENSITY OF LAWRENCE, KANSAS

VIEWED FROM NORTH

ELEVATION – 30 DEGREES

Our last visual - there are many charts, graphs and statistics that can tell us where the aged are - but we must keep in mind that like this three dimensional view of the population of Lawrence, population data is dynamic and the peaks and valleys illustrated by printed facts and figures may not be totally accurate by the time it is printed.

Lecture

Who Are The Aged?

We are in the midst of a demographic revolution. There is a greater proportion of aged individuals in our society than ever before, and the percentage continues to increase. Life expectancy for the average male born today sixty-seven and for the average female, seventy-five. As recently as 1900 life expectancy was about half a century or 47.3 years. This represents a gain of close to twenty five during this century. Ancient demographic figures of life expectancy give us an even more dramatic view of this changing profile.

Year	Life expectancy	
1000 BC	18 years	
1970 AD	70.9 years	+52.9 years in 3,000 years
1900	47.3 years	
1939	63.7 years	+23.6 years in 70 years
1970	70.9 years	

Prior to this century, the topic of the aged was not much of a concern to mankind. Exceptions to the rule existed, but a small percentage of the population survived into old age -- and a potentially dependent position. Looking at world life expectancy data illustrates that the phenomenon is not just here in Kansas, but world wide.

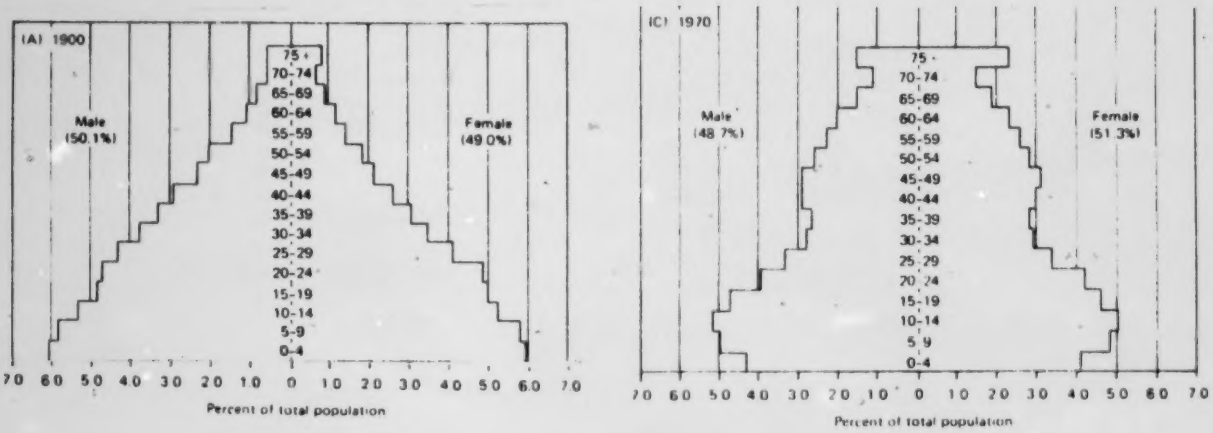
		Life expectancy at birth		*Population age 65 and over*	
Country	*Year*	*Male*	*Female*	*Number (in thousands)*	*Percent of total*
North America					
United States	1970	67	75	20,101	9.9
Canada	1971	68.8	75.2	1,744	8.1
Haiti	1972 (est.)	—44.5—		157	3.1
Mexico	1970	61.0	63.7	1,791	3.7
South America					
Argentina	1972 (est.)	64.1	70.2	1,805	7.5
Brazil	1970	—60.7—		4,760	5.1 (age 60+)
Venezuela	1970 (est.)	—63.8—		252	2.4
Asia					
China	1970 (est.)	—50.0—		—	—
Japan	1970	69.1	74.3	7,330	7.1
Iran	1971 (est.)	—50.0—		940	3.1
Syria	1970 (est.)	—52.8—		193	3.2
USSR	1970	65.0	74.0	28,514	11.8
Europe					
Austria	1970	66.6	73.7	1,047	14.2
Denmark	1969	70.8	75.7	590	12.1
France	1968	68.6	76.1	6,662	13.4
Hungary	1970	66.3	72.0	1,178	11.4
Netherlands	1971 (est.)	71.0	76.7	1,353	10.3
Sweden	1970	71.7	76.5	1,109	13.7
United Kingdom	1971	68.8	75.1	6,397	13.1
Africa					
Ethiopia	1968 (est.)	—38.5—		2,811	11.9 (age 45+)
Ghana	1970	—46.0—		311	3.6
Kenya	1969	46.9	51.2	391	3.6
S. Africa	1970	—49.0—		870	4.1
Uganda	1969	—47.5—		365	3.8
Zambia	1970	—43.5—		135	4.0 (age 60+)

SOURCE: United Nations. *Demographic Yearbook: 1972* (New York: United Nations), Tables 3 and 6 (1973). Reproduced by permission.

Note the contrast between industralized countries and underdeveloped countries, such as Africa. As these countries continue their own demographic revolutions, the aging impact

on world economy and social structures will continue to be felt.

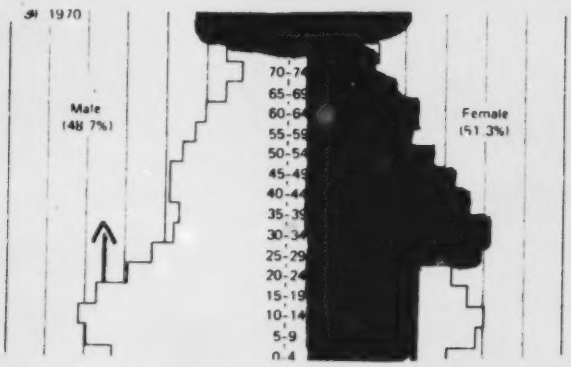
However, our attention needs to be focused on the older population in our own country. The United States age - sex population pyramid of 1900 and 1970 illustrate the basic demographic profile change that is taking place in all of our fifty states.



Age - sex population pyramids for the United States 1900, 1970 (U.S. Bureau of the Census. Census of Population: Characteristics of the Population, 1970.)

There are three demographic processes basic to the understanding of population dynamics that are important to explore as we find out who are the aged and what do these prophesy?

1. Fertility -- or how a particular birth cohort group will affect the population age composition. We are aware of the zero population growth goals -- and the 1950 baby boom. That baby boom moved through the pyramid causing an overload in hospital nurseries schools, colleges and society responded, rather than planned for the impact. This baby boom of the 1950's will mean a gerontology boom in 2010 - 2020. Society has some lead time to do some creative thinking to plan ahead by designing programming now that will meet the expected needs of a differently shaped pyramid.



Keep in mind that future fertility rates do not even affect this pyramid, for those cohorts have already been born. Of course, if we again exceed zero population growth, we are faced with a different set of population and survival problems.

2. Mortality -- the decrease in infant mortality and childhood infectious disease mortality has been the biggest factor in raising the age of life expectancy. Individuals have been 80, 90 and 100 years old for centuries, but because so many babies and young children died, the average life expectancy was lowered.

Demographic data concerning mortality of interest to our study include

a. A decrease in infant mortality

1935 55.7 deaths per 1,000 live births during first year.
1973 18.5 deaths per 1,000 live births during first year.

We know how many individuals were born in 1900 -- and we know that the infant mortality was high. That affected the eventual size of that birth cohort 65 years later in 1965. We also know how many individuals were born in 1970, but infant mortality has been substantially reduced, therefore a much larger percentage of that cohort group may reach age 65.

b. Control of disease

1900 39% survived to age 64
1970 72% survived to age 64

The control of infectious disease during this century also helped children and young adults survive to age 65. A look at the top ten causes of death in 1900 and 1970 show us that some diseases such as tuberculosis and diphtheria are no longer a "top ten" concern.

Death rates for the ten leading causes of death in 1900 with comparable rates for 1970 in the United States

	Rate (deaths per 1,000 population)		*Rank*	
*Cause of Death**	*1900*	*1970*	*1900*	*1970*
Influenza and pneumonia	202.2	30.9	1	5
Tuberculosis	194.4	2.6	2	—
Gastroenteritis (diseases of stomach and intestine)	142.7	0.9	3	—
Diseases of the heart	137.4	362.0	4	1
Cerebral hemorrhage and other vascular lesions	106.9	101.9	5	3
Chronic nephritis (kidney diseases)	81.0	3.7	6	—
All accidents	72.3	56.4	7	4
Cancer and other malignant neoplasms	64.0	162.8	8	2
Diseases of early infancy	62.6	21.4	9	6
Diphtheria	40.3	0.0	10	—

*Eighth Revision, International Classification of Diseases, Adapted, 1965.
SOURCE: Public Health Service, National Center for Health Statistics. *Vital Statistics of the United States, 1970, Volume II—Mortality*, Part A, Table 1-5; *Monthly Vital Statistics Report*, Volume 22, No. 13 (June 27, 1974), adapted from Tables 7 and 8.

c. Immigration and migration

From 1881 - 1930, the United States received almost 27.6 million immigrants, most of whom were 15 - 39 years old. These immigrants married, raised families and added to the population pyramid. They joined their U.S. cohort groups in the older aging profile. Immigration continues, but the numbers have decreased to our present annual statutory ceiling of 400,000.

But, within the U.S. there is a migration of older individuals to warmer climates as these figures of Florida, California and Texas indicate:

Population age 65 and over: ten leading states in the United States: 1970

Rank	*State*	*Number*	*Percent increase since 1960*	*Percent of state total in 1970*
1	New York	1,961,000	16.2	10.8
2	California	1,801,000	30.9	9.0
3	Pennsylvania	1,272,000	12.7	10.8
4	Illinois	1,094,000	12.2	9.8
5	Ohio	998,000	11.2	9.4
6	Texas	992,000	33.1	8.9
7	Florida	989,000	78.9	14.6
8	Michigan	753,000	18.0	8.5
9	New Jersey	697,000	24.4	9.7
10	Massachusetts	636,000	11.3	11.2
	United States	20,177,000	21.0	9.9

SOURCE: Adapted from United States Bureau of the Census. *Census of Population: 1970, General Population Characteristics*, (Washington, D.C.: United States Government Printing Office) Final Report, PC (1)-B1, Tables 59 and 62; *Census of Population: 1960, Characteristics of the Population, Volume I*, Part 1 (Washington, D.C.: United States Government Printing Office) United States Summary. Tables 55 and 59.

These pyramids, charts and figures merely paint the outline of who are the aged. It is our great grandparents, our grandparents, our parents and all the future generations -- and most of all, us. We are in that aging profile and age - sex pyramids and therefore have a right to be concerned. We can be a part of the planning to respond to this demographic revolution.

Group Exercise

What Are Specific Demographic Answers?

Where Do We Find Them?

Objectives

1. To familiarize participants with the wide variety of census materials available
2. To explore the broad scope of the demographic revolution
3. To gain information relevant to the demographic process
4. To stimulate discussion and individual insight concerning the impact of the Graying of America

Procedure

a) Participants are divided into work groups

b) Each group receives one set of questions and the appropriate resource materials

c) Each group utilizes their resources to discover the specific demographic answer and prepares a report page

d) The groups exchange lists so that all groups have at least one copy of each set of questions and answers

e) Each group shares their findings and impressions

f) Group discussion concerning the impact of:
   1. Housing arrangements
   2. Educational levels
   3. Voting patterns
   4. Income levels
   5. Ethnic characteristics
   6. Percentage of aged in specific areas
   7. Occupations of the 60+ population
   8. Taxation sources
   9. Medical services
   10. Others that are relevant to the group and the time

Closing Statement

We have merely scratched the surface of possible demographic analysis and data relevant to the concepts and issues of the demographic revolution. We know that there are more older people in the United States than in previous years, but that is but a small part of our overall picture. Demographic analysis can provide the descriptive parameters of tomorrow's older population. There are many more areas that we need to explore as we look at the social forces in later life and what this demographic revolutions means to all of us.

Demographic: Ten Questions

Resource: Kansas Statistical Abstract, 1974, Institute for Social and Environmental Studies, The University of Kansas

1. In 1970, how many women in Kansas were 96 years old?
(p. 24) 184

2. Which age group experienced the largest percent change 1960 - 1970 in Kansas?
(p. 25) 20-24 (51.5)

3. How many individuals voted for Humphrey & Muskie in November, 1968 in Shawnee County?
(p. 52) 21,735

4. What was the vote spread between Bennett & Miller in 1974 in Shawnee County?
(p. 60) Bennett 29,668 Miller 30,543 Difference 875

5. What was the median per household buying income estimate in 1973 in Shawnee County?
(p. 145) $10,295

6. How much cigarette stamp tax did Shawnee County collect in 1973 - 1974?
(p. 177) $277,694

7. How many fatal traffic accidents were there in Shawnee County in 1972?
(p. 231) 25

8. What was the value of fishing licenses issued to residents in 1973 in Kansas?
(p. 205) $805,938

9. What was the cost per pupil in District #501 school district in 1973?
(p. 99) $855.10

10. How many doctors are in Stanton County in 1974?
(p. 42) 0

How many in Shawnee, Sedgwick, Wyandotte and Johnson?
(p. 43) 230 377 258 184

Demography: Seven Questions

Resource: General Social and Economic Characteristics, Kansas, 1970 Census of Population, U.S. Department of Commerce, PC(1) C18

1. How many individuals were born in Mexico that now live in Topeka?
(p. 18-251 Table 81) Ethnic characteristics for Areas & Places 479

What is the second largest group of foreign born living in Topeka?
(p. 18-251) German 224

2. How many individuals in Topeka listed walked only as their means of transportation in 1970?
(p. 18-254 Table 82) Means of Transportation 2,523

3. Were there more native Kansans or those born in other states living in Topeka in 1970?
(p. 18-254 Table 82) State of Birth Born in State 83,320
Born out of State 33,421
49,899

What is the difference?
49,899

4. In 1970, what was the median school years completed in Topeka?
(p. 18-258 Table 83) Years of School Completed 12.4

5. How many individuals lived in homes for the aged in 1970 in Topeka?
(p. 18-260 Table 84) Type of Group Quarters 1,166

6. What is the largest group of foreign origin in Ellis County?
(p. 18-361 Table 119) Nativity, Parentage & Country of Origin USSR 1,374
Germany 402

In Shawnee County?
(p. 18-366 Table 119) Spanish descent 7,164

In McPherson County?
18-363 Sweden 1,143

7. What county in Kansas had the highest percentage of 65 + population in 1970?
Resource Aging In Kansas, 1971 White House Conference on Aging Report Services for the Aging Section, SRS, Topeka, Kansas

In Elk County

Group Exercise

Demographic: Six Questions

Resource: Social and Economic Characteristics of the Older Population 1974, U.S. Department of Commerce, Current Population Reports, Special Studies, Series p-23, No.57, Issued November, 1975

1. What is the difference in percentage of widowed individuals between age 65 - 69 and 85 +?

(p.7 Table 8)

M	8.8 (65-69)		F	36.5 (65-69)
	43.4 (85+)			76.9 (85+)
	34.6			40.4

2. How many children were ever born to white women 85 +; black women 85 +?

(p.8 Table 10)

W	2,532	B 261

3. What percent of the male 65 + population had less than five years of elementary school completed in 1960?

(p.17 Table 16)

W	20.5	B 57.1

In 1970?

(p.17 Table 16)

W	13.1	B 44.2

4. What percent of all the races & sex reportedly voted in November 1974?

(p.21 Table 20) 51.4 (65+)

5. What percent of the 65 + population were listed as farmers as their major occupation in 1973?

(p.29 Table 29)

M	18.3	W 3.9

6. What is the difference in the morality figures for United States, Kansas & HSA II in heart disease?

(Resource: Health Systems Plan 1978, Northeast Kansas Health System Agency)

12 US 339.0
KS 359.4
HSA II 368.3

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SOCIAL GERONTOLOGY

UNIT #2
SOCIETAL STRUCTURE AND ITS RELATIONSHIP TO THE AGED (CS 311)

SESSION #2
HISTORICAL TRENDS AND CHANGES IN SOCIAL GERONTOLOGY (CS 311-B)

Resource leaders: Jeanne C. Tucker, Director, Gerontology Institute, Washburn University
Vivian Umbarger, Coordinator, Gerontology Institute, Washburn University

Suggested Agenda

Introductory lecture:	Were they the "Good Old Days?"
Video presentation:	How do we interpret cultural impact on aging?
Group exercise:	Why is housing important?
Lecture discussion:	What about our mid-western/rural values use of older Kansans?

Feedback and evaluation

Objectives of session #2

1. Increase awareness of culturally based view of the aging process and older individuals.
2. Increase awareness of the relationship among age linked attitudes and basic cultural values concerning old/new, modern/traditional, old/young.
3. Discuss the impact of the elderly as a social problem.
4. Discuss variations in the characteristics, needs and resources of the ethnic, cultural and geographic sub-populations of older individuals.
5. Discuss housing patterns of older individuals and socialization processes.
6. Discuss the impact of population growth, urbanization and industrialization on the older individual.
7. Discuss the unique mid-western, rural value system and its relationship to older individuals.
8. Discuss the nature and cause of intergenerational conflicts between the elderly and the young.
9. Have available materials and bibliographic materials that would allow the participant to research historical and cultural trends on their own.
10. Increase awareness of appropriate and inappropriate community responses to the needs of older individuals from various cultural backgrounds.

Introductory Lecture

Were They the Good Old Days?

The romance of the west, the glamour of Front Street, Miss Kitty, Doc and Matt -- could it be that we are looking at the "good old days" with rose colored glasses? Where do you suppose our mid west value systems come from? Why do we seem to be caught up in a love affair with antiques, cowboys and extensive genealogy research, but regard aging negatively? Perhaps to better understand Kansas' aging population, we need to step back and objectively look at the early daily life in Kansas and compare it with our present day society.

Socialization took place in those daily life experiences. An individual developed into a social being capable of appropriate and inappropriate participation in the existing society. The socialization process is never complete in our complex and fast changing society, but we learn our culture and social system so we can potentially put that system to our use. If we do not understand the system, our lives can be confusing and unpredicable.

Let's step back in history via some articles that have appeared in Kanhistique, a monthly publication that includes personal reminiscences and reprints about a Kansas daily life in the "good old days." Let's start with that glamourous institution, the early saloon.

1. The Weren't Like the Movies, Early Kansas Saloons, June, 1976, p.12 by David Dary

   It has been 95 years since open saloons were legal in Kansas, but names such as the Side Track, Buckhorn, Pearl, Tavern, Saratoga, Star of the West, Alamo, Rowdy Joe's, Old Red's and Longbranch have not passed from history.

   The modern-day version of a Kansas saloon, as pictured in Western movies or on television, sometimes lacks authenticity. Most old-time saloons in Kansas were not fabulous places of plush pleasure with block-long bars and regular floor shows featuring beautiful girls doing the can-can.

   The very early saloons consisted of wood planks resting on two barrels in a tent or dugout or beside a wagon on the prairie near a military post. As Kansas grew after the Civil War, more permanent structures were built

   The typical saloon of the 1860's was a long narrow room, dimly lit, with a small and not very fancy bar. There were a few tables and chairs, and about the only shiny objects were cuspidors - essential for those who "chawed."

   Everything else was dirty and smelly. Saloons were unforgettable for their blending odors of tobacco, liquor, straw, horses, kerosene and the sometimes sizzling spit of tobacco juice on the hot stove during the winter.

And have you ever given much thought to the prairie and how it might have influenced the people that lived on it?

2. Trees and the Pioneer, July 1976, p. 1 by Paul F. Long

   Timber was a most important commodity to the pioneers. What a tremendous impact the scarcity of trees in many parts of Kansas must have made on early settlers. One can only imagine the feelings of these early pioneers who came to Kansas from the wooded states of the East. Especially would this shortage have been acutely suffered by those persons who passed on through the comparatively forested areas of eastern Kansas and settled in the western two-thirds of the State. Something of the importance of timber or the hardships created by the absence of forested stretches can be gauged by noting the uses made by pioneers of wood products. Place-names, the naming of creeks and rivers, and

the christening of towns and settlements are also indicative of the role trees assumed in their lives. In untimbered localities one would assume some of these names originated out of optimism of better times to come when the plains might flower with orchards or woodlots.

And, of course, just the pace of everyday life was different as depicted in these memories.

3. East Side, West Side, June 1977, p.12 by Rebecca Worley Tetlow, Downs

In those yesteryears the family touring cars were cranked up only for going places too far to walk, so teachers, businessmen, clerks, the telephone girls, the railroad shopmen, nearly every working person walked to work and home again every day. Our parents walked to evening school entertainments, to visit friends, to church, everywhere. Housewives, old, young and in-between, walked downtown to shop, the young ones pushing baby carriages or toddler go-carts. Couples keeping company walked to the Pastime Theater to hold hands and watch the greats of silent filmdom.

People often walked to the depot on summer evenings, too, to drop letters in the slot of the mail car, or just to see who got on the train. On the spacious, red brick platform and the wide walk that extended a block along the track, we'd see friends who'd come to see relatives off, friends who were there for the same reason we were, and maybe others who'd come in from the farm to load a five gallon can of cream on the baggage car.

One evening, a very sick young neighbor was carried onto the train, to go to the nearest hospital sixty miles away, at Concordia. Our father and three other men had carried her the several blocks from her home on an ordinary army cot.

We kids looked up to the people who worked around the train. The conductor in his black suit and white shirt, his big watch in hand, his boarding stool ready; the engineer high up in the cab of the big, black, steam locomotive, with his red bandana around his neck; the other train men and the depot agent; all so busy with the important job of getting everything and everybody on board before the train whistled out of town, bound for some wonderful far-off place.

The wide sidewalk on the main business street, on Saturday night, was the place and the time to see people from miles around as they went about their errands with plenty of time to stop and visit. In summer, the men often sat visiting on the running boards of cars parked at the curb. Their wives stood in clusters, sat together in the open cars, or went to a store that provided an area equipped with benches and chairs. Saturday nights the stores did their largest volume of business so they didn't turn out the lights and lock up until the sidewalks were deserted.

Little tots rode kiddie cars and tricycles or pushed doll buggies back and forth on the walks in front of their homes. Slightly older ones rode scooters or coaster wagons to the end of the block, or as far as main street.

Riding and steering a coaster wagon was something little boys did much more than little girls. They supported themselves with one knee in the wagon, one hand gripping the side. They steered with the other hand, and using the other foot on the sidewalk for go-power, got up some pretty good speeds, but a wheel off the edge of the walk could land the wagon and rider upside down. A wagon tongue was a tricky steering device, so it behooved pedestrians to give coaster wagon riders the whole sidewalk.

Girls played hopscotch, going to the mill, and the game television calls tic-tac-toe, we called it cat, on the sidewalk. When we couldn't come by a piece of chalk, we drew the diagrams and marked our x's and o's with a soft rock. We were away ahead of modern pet-rock fanciers, for a good marking rock, when found, was cherished and kept in a safe place behind the porch lattice. On the sidwalk, too, we played jacks, bounced balls and some of

us spun tops with the boys.

Social values are difficult to measure and "see" and can only be inferred from specific behavior. But as we look at the setting for socialization for our over 65 population, perhaps we might be better able to interpret certain behavior patterns and interact more successfully with older Kansans.

As we discussed last week, the demography of the aging population is changing and creating new and unsolved problems. Keeping a historical perspective in mind, let's review some of the national demographic materials and see if they might compound some of the concerns and problems of older Kansans.

Table 1. Marital status -- compare the historical value system concerning divorce, and the ever present statistics concerning the probability of women being widowed for ten years of their lives with these 1960 and 1970 statistics.

Table 2. Mobility and urbanization -- many younger individuals are moving into the urban areas and leaving the farm and rural life and this certainly affects the older Kansan. How? What kind of behavior modification would an older farmer need to make to appropriately respond to urban housing patterns?

Table 3. Home ownership -- Kansans are known for their independent spirits -- what happens to an older home owner when they move into a rented living space or a smaller institutional setting?

Table 4. Institutional living -- contrary to myths, there are small percentages of older individuals living in institutions, with most living independent lives. Do you think it would be more difficult for a rural or urban personality type to move into an institutional setting?

Table 5. Income -- with the rising inflation patterns, how would you feel this will affect the older population?

Table 6. Occupations -- what would you imagine to be the principle difference between retirement adjustments of farmers and blue collar workers?

Table 7. Education -- more and more older individuals are going back to school as our cultural values change and it becomes O.K. for lifelong enrichment experiences in contrast to survival experiences.

Table 8. Immigrants -- is Kansas a melting pot, or do some of the old country ways influence the value processing of the older Kansan?

Historical Trends Handout for Good Old Days lecture

1 Persons 65 years old and over tend to live with few other persons and with relatives only. In 1974, about 80 percent of all families with a head of this age consisted of two persons. Only about 2 percent of the households headed by a persons 65 or over included nonrelatives of the head. Women living alone or with nonrelatives only accounted for a significant portion—about one-third—of all household heads 65 years and over. This type of household was second in this age group to husband-wife households, which accounted for about 46 percent of all households headed by persons 65 or over.

MARITAL STATUS OF PERSONS 65 YEARS OLD AND OVER, BY RACE AND SEX: 1974, 1970, AND 1960

(Numbers in thousands. Civilian noninstitutional population)

Marital status and race	Male			Female		
	1974	1970	1960	1974	1970	1960
WHITE						
Total, 65 years and over....thousands..	7,727	7,661	6,720	11,027	10,692	8,239
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Single	4.5	7.4	7.8	6.5	8.3	8.8
Married, spouse present	78.4	69.5	67.7	38.2	34.5	35.4
Married, spouse absent	1.4	3.6	3.5	1.2	2.3	2.5
Widowed	13.6	16.5	18.7	51.5	51.7	51.3
Divorced	2.1	2.9	2.3	2.6	3.1	2.0
NEGRO						
Total, 65 years and over....thousands..	715	691	[1]589	956	891	[1]660
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Single	5.2	8.1	6.6	4.7	6.1	4.4
Married, spouse present	59.6	55.7	58.5	25.5	26.1	26.9
Married, spouse absent	9.1	8.6	8.1	3.2	6.0	5.3
Widowed	22.8	23.7	24.4	61.0	58.1	61.4
Divorced	3.6	3.9	2.5	2.6	3.8	2.0

[1]Negro and other races.

Source: U.S. Department of Commerce, Bureau of the Census.

2 Persons 65 and over change residence infrequently - at less than half the rate of the total population. About four out of five persons (79 percent) 65 and over lived in the same house in 1974 as they did in 1970. Even so, 3.5 million persons 65 and over moved during the 4-year period; many of those who moved (60 percent) remained within the same county.

About two out of three persons 65 and over lived in metropolitan areas in 1970, and about half of these lived in the central cities. In nonmetropolitan areas, a small percentage lived on farms, whereas the bulk of the residents were about equally divided between urban and rural-nonfarm areas.

PERSONS 65 YEARS OLD AND OVER, BY METROPOLITAN-NONMETROPOLITAN RESIDENCE AND SEX: 1970

Residence	Both sexes	Male	Female
Total, 65 years and over..thousands..	20,102	8,438	11,664
Percent	100.0	100.0	100.0
Metropolitan	61.2	62.5	65.4
Central cities	31.1	32.4	35.4
Other urban	23.5	22.8	24.0
Rural nonfarm	5.3	5.8	5.0
Rural farm	1.2	1.5	1.0
Nonmetropolitan	35.8	37.5	31.6
Urban	15.1	11.5	16.0
Rural nonfarm	16.3	17.6	15.1
Rural farm	4.4	5.1	3.5

Source: U.S. Department of Commerce, Bureau of the Census.

3 Household heads 65 and over hold their own in home ownership compared with the total population. In 1970, 63 percent of all households, and 68 percent of those with a head 65 and over, were owner occupied.

An overwhelming proportion (around 70 percent) of the owner occupied units with a head of household 65 and over had been built prior to 1950 with more than half having been built before 1940. Similarly, a substantial portion of these units had been occupied by the current owners for more than 20 years. Greater percentages of heads 75 and over than of those 65 to 74 in the corresponding type of household were living in structures built before 1940 and had moved into their units before 1950.

Table 43. HOUSEHOLDS BY TENURE FOR TOTAL HOUSEHOLDS AND HOUSEHOLDS WITH HEAD 65 YEARS OLD AND OVER, BY REGION: 1970

(Numbers in thousands)

Tenure	United States	Northeast	North Central	South	West
ALL HOUSEHOLDS					
Total	63,573	15,515	17,568	19,307	11,184
Owner-occupied	40,268	9,027	12,030	12,569	6,611
Percent	63.3	58.2	68.5	65.1	59.1
Renter-occupied	23,305	6,488	5,538	6,738	1,543
Percent	36.7	41.8	31.5	34.9	10.6
HOUSEHOLDS WITH HEAD 65 YEARS AND OVER					
Total	12,212	3,074	3,513	3,728	1,927
Owner-occupied	8,339	1,783	2,594	2,701	1,261
Percent	68.1	58.0	73.8	72.5	65.4
Renter-occupied	3,903	1,291	919	1,027	666
Percent	31.9	42.0	26.2	27.5	34.6

Source: U.S. Department of Commerce, Bureau of the Census.

4 Approximately 1 million persons 65 years and over were living in institutions in 1970. About 8 out of 10 of these were in homes for the aged and another 1 out of 10 were in mental hospitals and residential treatment centers. The remainder were patients in hospitals because of physical reasons or were inmates of correctional and other institutions. About twice as many women as men were in institutions, reflecting their greater incidence in homes for the aged which is in harmony with their greater numbers among the older population.

Table 11. INMATES OF INSTITUTIONS BY TYPE OF INSTITUTION FOR PERSONS 65 YEARS OLD AND OVER, BY SEX: 1970

(Numbers in thousands)

Type of institution	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Total persons, 65 years and over	968	100.0	314	100.0	654	100.0
Prisons and reformatories	2	0.2	2	0.6	-	-
Local jails and workhouses	2	0.2	2	0.6	-	-
Mental hospitals and residential treatment centers	113	11.7	51	16.2	62	9.5
Tuberculosis hospitals	5	0.5	3	1.0	2	0.3
Chronic disease hospitals	35	3.6	16	5.1	19	2.9
Homes for the aged and dependent	796	82.2	234	74.5	562	85.9
All other	15	1.5	6	1.9	9	1.4

- Represents zero or rounds to zero.

Source: U.S. Department of Commerce, Bureau of the Census.

5 Approximately one in every six persons 65 years old or over (16 percent) was below the low-income level in 1973. Smaller percentages of persons 55 to 64 than of those 65 and over were below the low-income level. Women 65 and over were more likely than men to be below this level, about 19 percent compared with 12 percent. Similarly, older persons living in nonmetropolitan areas were more likely than metropolitan residents to be below the low-income level, 23 percent versus 13 percent.

LOW-INCOME STATUS OF PERSONS IN THE TOTAL POPULATION AND AMONG PERSONS 65 YEARS OLD AND OVER: 1966 TO 1972

(Numbers in thousands. Persons as of March of following year; see Note, page 31. Numbers exclude unrelated individuals under 14 years old, inmates of institutions and members of Armed Forces living in barracks)

Year	All persons			Persons 65 years and over		
	Total	Below low-income level		Total	Below low-income level	
		Number	Percent		Number	Percent
1972	206,001	21,160	11.9	20,117	3,738	18.6
1971	201,551	25,559	12.5	19,827	4,273	21.6
1970	202,189	25,522	12.6	19,254	4,709	24.5
1969	199,818	24,281	12.1	18,899	4,787	25.3
1968	197,618	25,377	12.8	18,519	4,632	25.0
1967	195,677	27,775	14.2	18,215	5,388	29.5
1966	193,390	28,510	14.7	17,931	5,114	28.5

Source: U.S. Department of Commerce, Bureau of the Census.

6 There were also variations by age within the major occupation groups for persons 65 years and over and those 55 to 64 years. A considerably larger proportion of men 55 to 64 years old than of those 65 years old and over were in blue-collar occupations, 44 percent compared with 27 percent. Among women, 34 percent of those 65 years and over were in service occupations, but only 25 percent of those 55 to 64 years were in these occupations.

MAJOR OCCUPATION GROUP OF PERSONS 65 YEARS OLD AND OVER, AND PERSONS 55 TO 64 YEARS OLD, BY SEX: 1973

Major occupation group	Male				Female			
	65 years and over			55 to 64 years	65 years and over			55 to 64 years
	Total	65 to 69 years	70 years and over		Total	65 to 69 years	70 years and over	
Total.....thousands..	1,851	1,059	792	6,833	1,024	619	405	4,062
Percent.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
White-collar workers.....	41.8	41.6	41.9	39.8	51.6	53.8	48.1	55.4
Professional, tech.,and kind. wkrs...	11.1	11.3	10.9	10.2	11.9	12.0	11.9	13.0
Managers and administrators.....	15.6	15.6	15.7	16.6	8.5	7.6	9.9	7.6
Sales workers.....	9.1	9.3	8.8	6.6	11.1	11.1	11.1	8.3
Clerical and kindred workers.....	5.9	5.6	6.6	6.5	19.9	22.9	15.3	26.5
Blue-collar workers.....	27.0	29.2	24.0	43.7	10.4	11.3	8.9	17.6
Service workers.....	13.0	13.1	12.8	8.8	34.1	31.3	38.3	24.9
Farm workers.....	18.3	16.0	21.3	7.7	3.9	3.6	4.4	2.1

Source: U.S. Department of Labor, Bureau of Labor Statistics.

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Table 16. YEARS OF SCHOOL COMPLETED BY PERSONS 65 YEARS OLD AND OVER, BY RACE AND SEX: 1974, 1970, AND 1960

Years of school completed and race	1974		1970		1960	
	Male	Female	Male	Female	Male	Female
WHITE						
Total, 65 years and over..thousands..	7,727	11,027	7,664	10,696	6,720	8,239
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Elementary: Less than 5 years	10.3	8.8	13.1	10.2	20.5	15.6
5 to 7 years	16.1	14.6	20.5	17.7	23.2	20.4
8 years	25.9	24.5	25.8	25.0	27.4	28.8
High school: 1 to 3 years	11.1	15.6	11.8	16.1	10.9	13.3
4 years	17.5	22.0	12.7	17.5	8.2	12.2
College: 1 to 3 years	6.5	8.3	6.3	8.1	5.2	6.4
4 years or more	9.2	6.2	6.8	5.2	4.6	3.3
NEGRO						
Total, 65 years and over..thousands..	715	956	692	894	[1]589	[1]660
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Elementary: Less than 5 years	15.2	32.1	14.2	33.4	57.1	48.8
5 to 7 years	27.0	29.4	27.4	30.2	21.6	25.7
8 years	10.8	12.2	10.7	13.1	9.5	11.4
High school: 1 to 3 years	7.3	13.6	8.9	11.8	5.1	6.6
4 years	4.3	7.9	4.9	6.4	3.4	4.1
College: 1 to 3 years	2.9	2.2	2.2	2.7	1.8	2.0
4 years or more	2.5	2.5	1.8	2.4	1.5	1.4

[1]Negro and other races.

Source: U.S. Department of Commerce, Bureau of the Census.

8 Persons 65 years and over comprise a larger share—about one in every five overall—of the foreign stock population (the foreign born plus native persons of foreign or mixed parentage) than of the total population (1 in every 10). One-third of the foreign-born population and one-sixth of native persons of foreign or mixed parentage were 65 years and older.

FOREIGN STOCK POPULATION BY COUNTRY OF ORIGIN: 1970

Country of origin	Total foreign stock		Foreign stock 65 years and over	
	Number (thousands)	Percent	Number (thousands)	Percent
All countries	33,575	100.0	6,975	20.8
United Kingdom	2,465	7.3	657	26.7
Ireland	1,450	4.3	466	32.1
Norway	615	1.8	220	35.8
Sweden	806	2.4	311	38.6
Denmark	326	1.0	114	35.0
Netherlands	384	1.1	78	20.3
France	343	1.0	82	23.9
Germany	3,622	10.8	1,275	35.2
Poland	2,374	7.1	432	18.2
Czechoslovakia	760	2.3	173	22.8
Austria	975	2.9	245	25.1
Hungary	604	1.8	118	19.5
Yugoslavia	447	1.3	60	13.4
U.S.S.R.	1,943	5.8	480	24.7
Lithuania	331	1.0	67	20.2
Greece	435	1.3	53	12.2
Italy	4,241	12.6	680	16.0
China	339	1.0	24	7.1
Japan	391	1.2	35	8.9
Canada	3,035	9.0	550	18.1
Mexico	2,339	7.0	144	6.2
Cuba	561	1.7	33	5.9
Other West Indies	385	1.1	29	7.5
Other Central and South America	578	1.7	22	3.8
All other	2,783	8.3	418	15.0

Source: U.S. Department of Commerce, Bureau of the Census.

Video Presentation

How Do We Interpret Cultural Impact on Aging?

1. Do Not Go Gently, 16 mm film (four reels, two hours) obtained from Palmer Film Service, 611 Howard Street, San Francisco, California 94105.

   A pictorial essay of the Tenderloin District of San Francisco and the older residents of that district.

   Parts of reel #2 were shown and discussed.

   A. Cultural heritage of older Chinaman living alone in a hotel and the changing value systems that were taking place around him. He displays an inability to respond appropriately to a changing society with his stagnant socialization process abilities.

   B. Communal gardens in Germany. An adaptation of old value systems translated into alternative ways of living and behaving.

2. Over Easy Television Program with Hugh Downs, (video cassette)

   A. Tour of Chinatown -- shows an older, retired Chinese actor that feels cultural knowledge is not being translated to the younger generation. He volunteers his time to take grade school children on educational tours of Chinatown, pointing out old and new values.

   B. Domino Park -- an adaptation by older Cubans to create a life space for themselves in a new country. Unused parking lot is gradually transformed into a social gathering place for individuals with common interests and common language.

Group Exercise

Why Is Housing Important?

Housing represents more than mere physical surroundings. It is a reflection of the socio-cultural conditions under which one must live on a daily basis. One's personal and family dispositions, values and behaviors are influenced and shaped by our surroundings. History, culture and our environment all combine in our socialization process. This exercise is designed to look at appropriate and inappropriate physical surroundings that might play a part in assisting an older individual adapt to life changes.

Exercise: Have the participants arrange their chairs in one discussion circle (if there are more than 30 participants, divide the group and utilize other discussion leaders and handout materials.) Discuss the picture and pass it around the group, allowing time for participants to add their own cultural views to the discussion.

Suggest Discussion Guide

1) Older individuals need as many alternatives in housing situations as all segments of population. Can you fantasize the relationship of the two women moving from one housing site to another?

2) No matter what living space - shouldn't there be a chance for personal identity and a few familiar items?

3) The sensible move from unsafe housing to cheerful, safe housing may disengage the older individual from a lifetime support system of primary and secondary.

4) Man does not have to do all the adapting - the environment can be adapted to new needs and life situations, can't it?

5) Environmental adaptations for older individuals ultimately benefit the entire society.

6) Back to back linear conversation does not encourage group interaction. What other physical features make one environment more appropriate?

7) How might "front porches" be adapted to better serve the needs of social interaction of older individuals?

8) Opportunities for older individuals to <u>give</u> of themselves to the younger generation are as important as receiving needed support services.

9) Men traditionally seem to like out of door activity - but, also may benefit from a continuity of enjoyed activities.

10) Changing cultural attitudes and expectations may need altered social programming to respond to coming generations.

11) Social environments should be available to offer varied, lively, "fourth of July" settings for social interaction ----.

12) --- and a quiet, personal life space to share companionship with a significant other - or in pleasurable solitary endeavors.

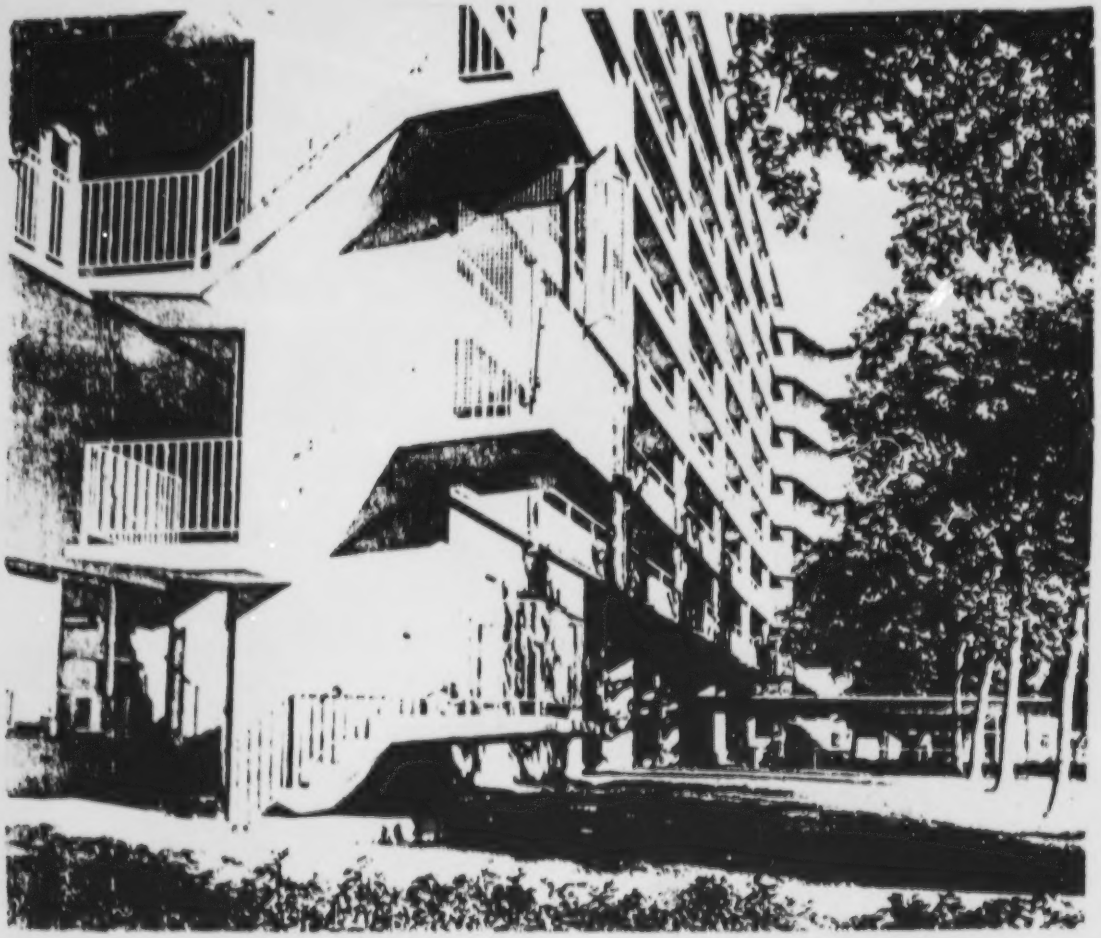
13) The physical surrounding may be altered - farm to brick high rise - but, the farmers joy of continued, familiar activities can be adapted.

14) For coming generations, we may need to keep in mind their cultural values, needs and expectations and respond with appropriate planning.

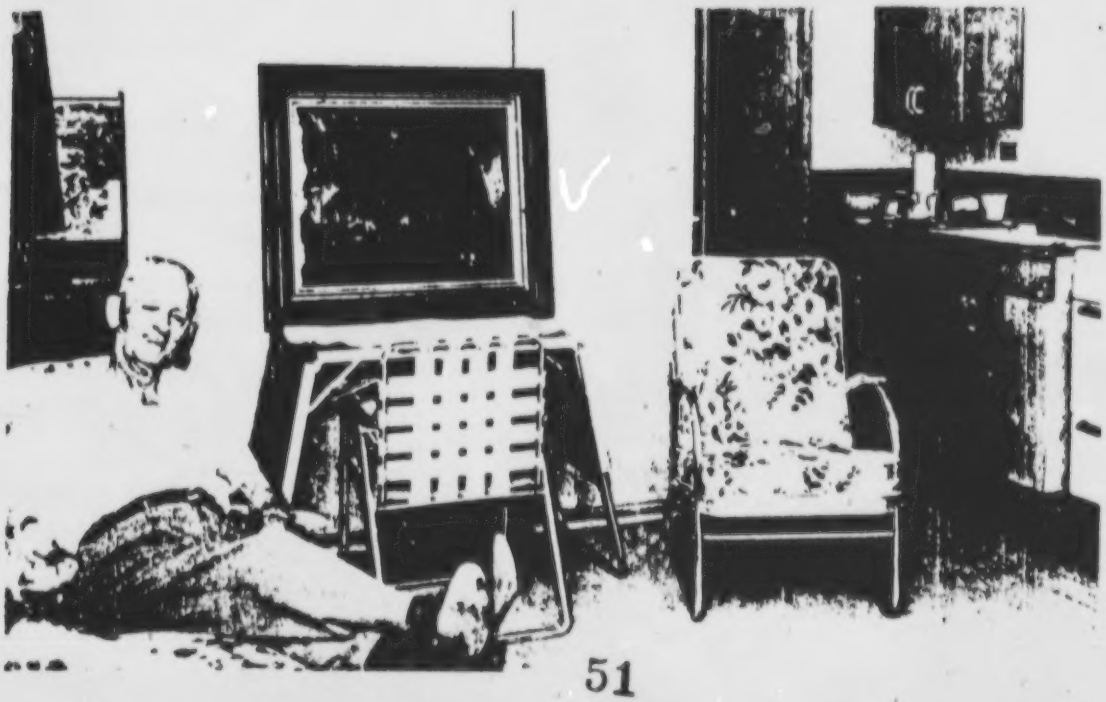
Picture these steps in the winter - and the courtyard

1

2



Be it ever so humble - those things are mine



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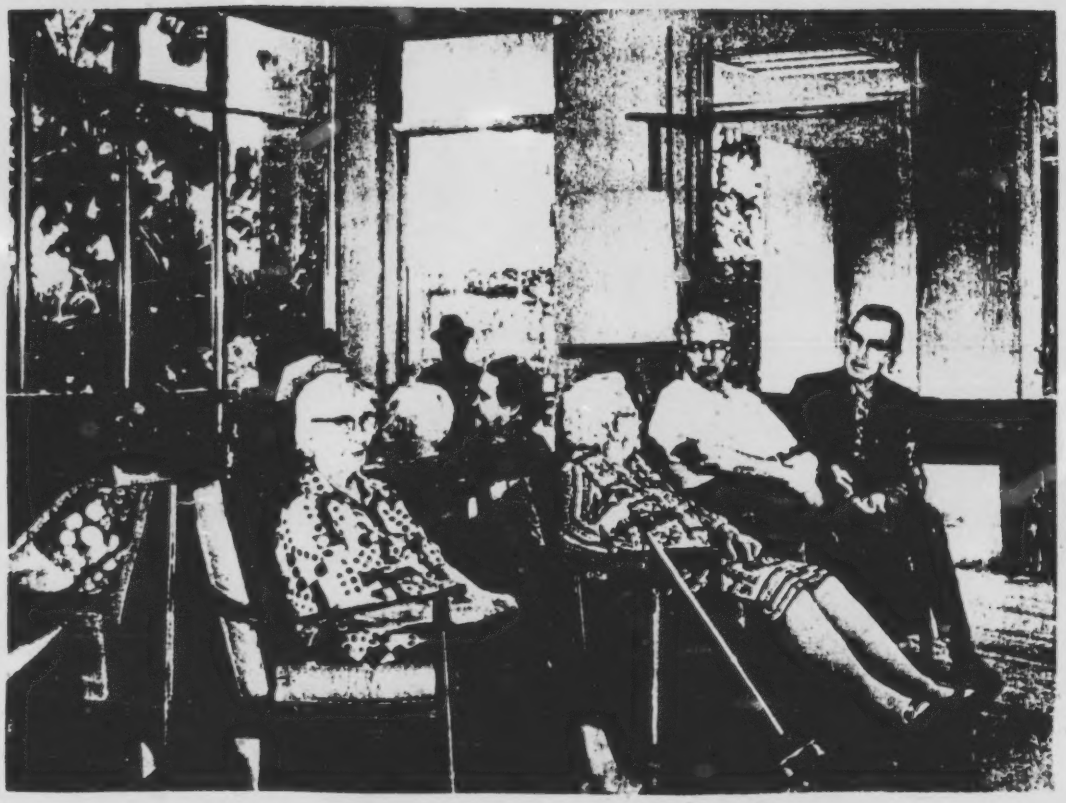
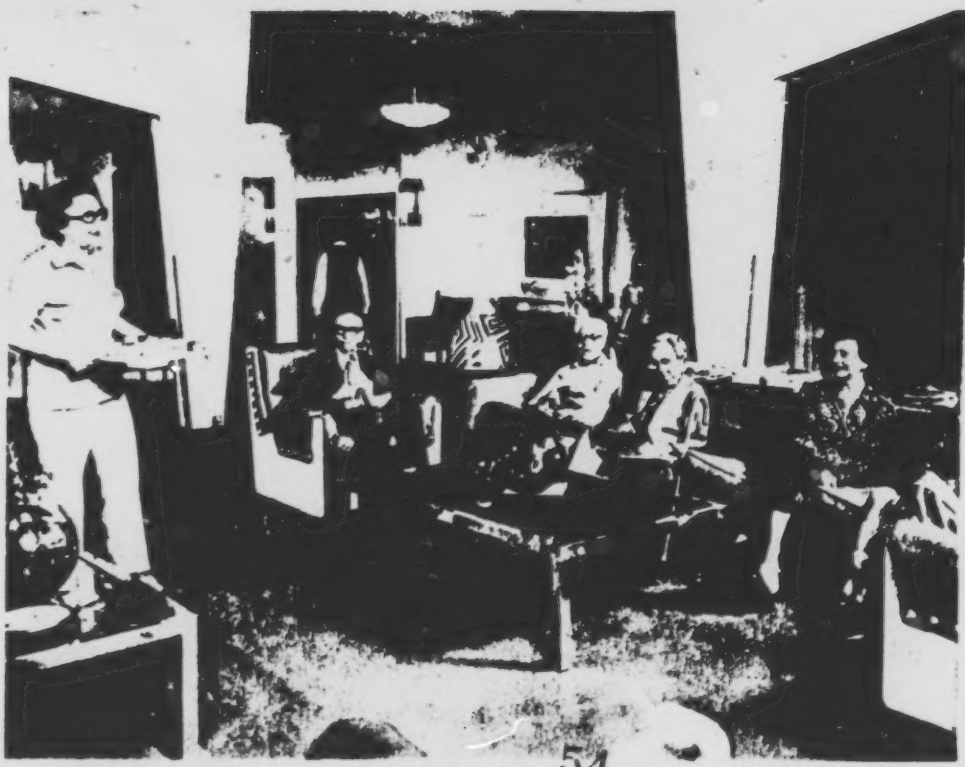
42 5 I'm a little slower and don't see the traffic signs like I used to





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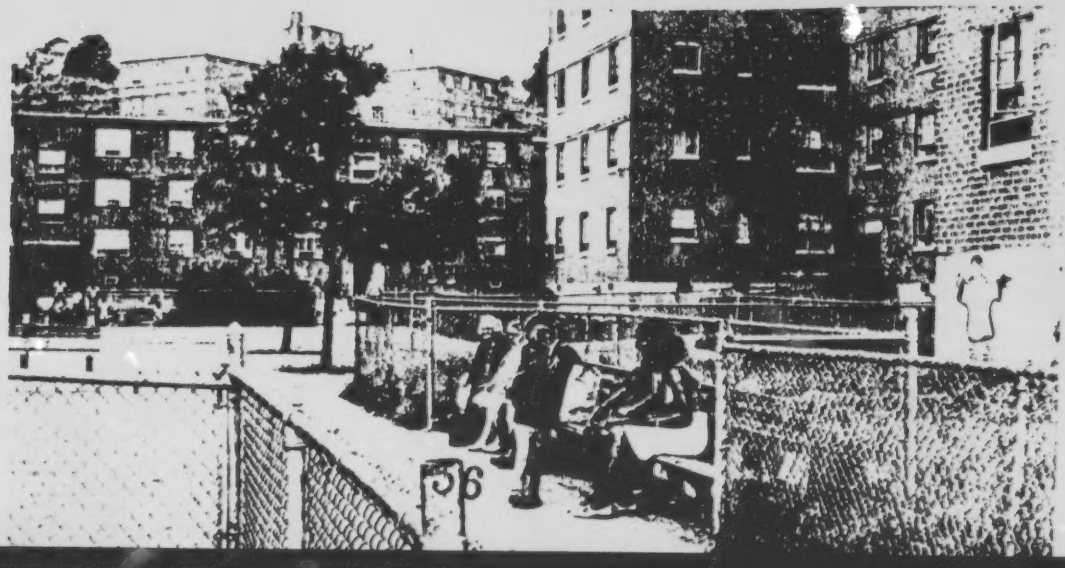
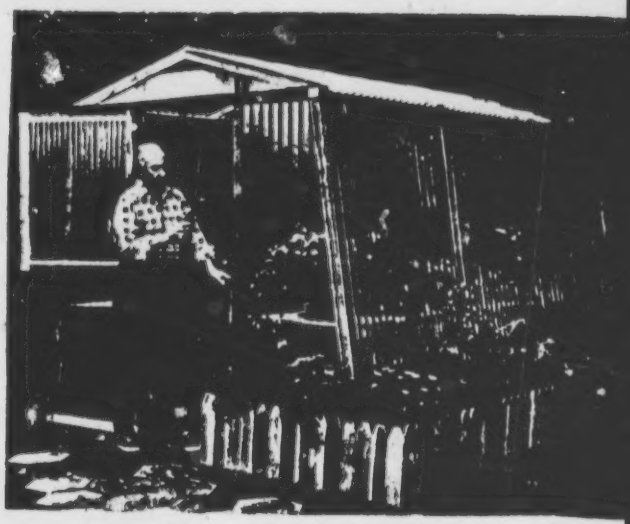
Remember the front porch and the fellowship shared there?

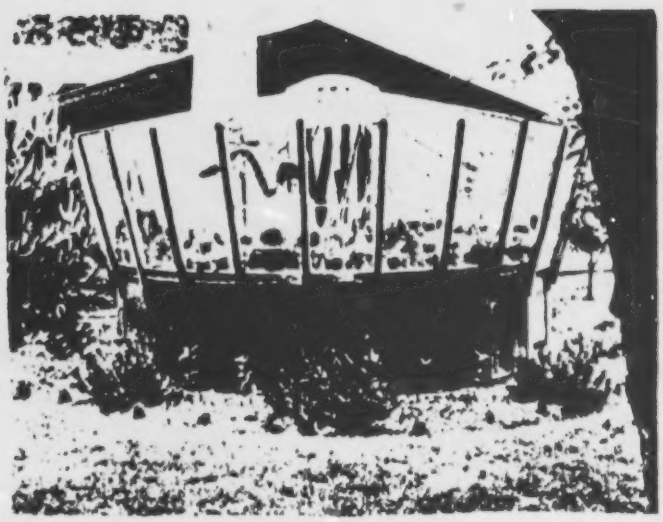


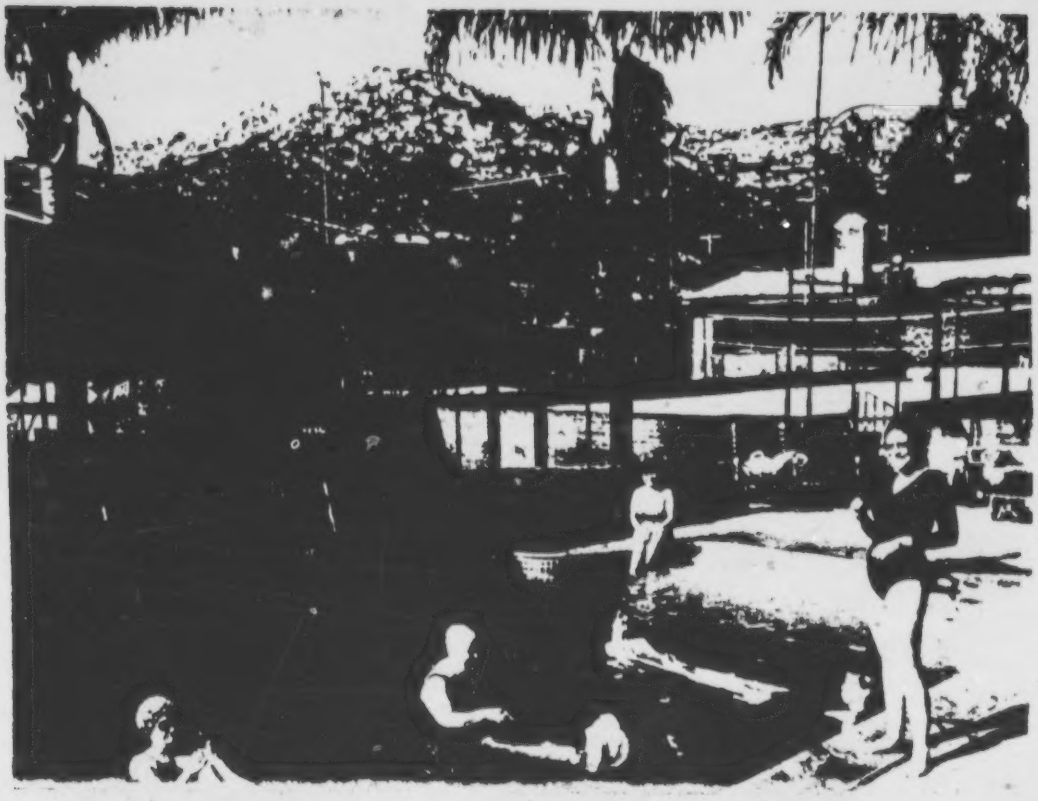
A fourth of July atmosphere ------

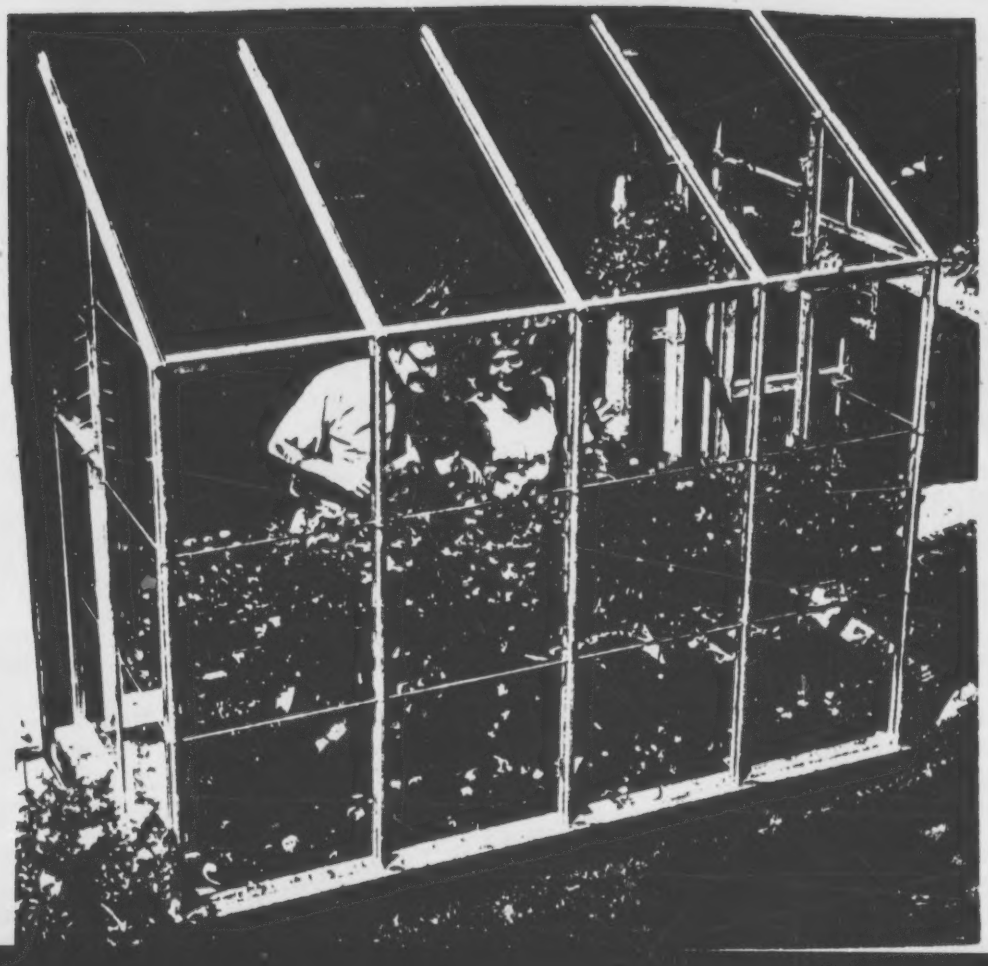
13

A green thumb can flourish even in a stone building









Lecture and Group Discussion

What About the Mid-West/Rural Value System of Older Kansans

Demographic views of the Kansas rural elderly reveal trends that sociologist have studied for a long time, but which those working with older individuals may have ignored. During the last three decades the American population has become increasingly urbanized. This is an on-going process and is largely due to the out-migration of the young to urban settings to seek career opportunities. And, as the young leave rural setting, this certainly affects the percentage of older individuals that we find in overall population figures. Kansas is the top ten states in percent of its population that are over 65 -- 12.6. This fact, and the value system that many older "city dwellers" brought from their rural heritage should be considered as we study social gerontology.

It is impossible to discuss these rural older people as a homogenous group, but there may be common values that will help us interact with the present generation of older farmers. As long as we keep in mind that there are unique subcultures in different rural area that reflect various ethnic backgrounds, religious beliefs and geographic loyalities, we may be able to discuss common values and increase our awareness of older Kansans.

According to a paper by Dr. Melvin A. White of the Rocky Mountain Gerontology Center, University of Utah, Salt Lake City entitled "Values of Elderly Differ in Rural Setting," there are eight values that rural elderly hold in common.

1. Independent -- self reliant, self sufficient

Independence or the American value of being the master over one's own destiny and not depending on others. The image of the self reliant cowboy and the romanticized portrayal of those early pioneers that "carried their own weight." If one becomes dependent on the church or social agencies, one loses status and is no longer perceived as a western hero. There are many opportunities in rural settings for cooperative arrangements or interdependence, such as shared barn-raising, bringing in the harvest, but chronic rather than acute dependence is much harder to cope with and the older rural individual may find it difficult to adjust to a dependant social position.

2. Ambitious -- hard working, aspiring

The Protestant work ethic is related to independence and self sufficiency. Hard work that is goal oriented -- raising a crop, building a fence, all hard work and aimed at the completion of a task that will enhance the rural world. As a person ages, and no longer has the physical energy to mend the fence, mild the cows, they may feel depressed because they can no longer be perceived as a hard worker and their self image may suffer.

3. Freedom -- free choice

Go West, young man and make your fortune. If one is independent and hardworking, one can be and do anything. You can rise beyone the present status in life and accomplish whatever you work hard enought to do or "pull yourself up by your own bootstraps." And, if you personally are unable to be the President of the United States, perhaps your son or daughter might work hard and obtain that lofty height.

4. Sense of Accomplishment -- lasting contribution

For early homesteaders endured incredible hardships so that their sons and daughters might inherit the "good land." The farm may change in appearance from generation to generation, but the pride of winning the struggle with the land and taming it to their use is a basic value that older Kansans' behavior still indicates is

strong. And what happens when all the children go off to college and no one wants to stay on the farm -- and because of decreasing physical energy, or death of a spouse, the farm has to be sold to strangers?

5. Logical -- consistent, rational
"Down to earth" is a good expression for farmers. A rural life style has forced individuals to be realistic. Nature is logical and real, and as one deals with raising livestock and crops, there does seem to be a season for all things and things for all seasons. Practical now solutions to problems need to be supplied rather that taking a long, round about intellectualized approach.

6. Conservative -- resistance to change, status quo
If it worked for my father, it will work for me. Because of the survival battle with nature, one is not so quick to try every new invention, if the old one is working. Political conservatism is probably an outgrowth, as we find that historically the conservative candidate comes from the rural area and is supported by the rural vote.

7. Integrity -- honest, sincere, truthful
"Shake on it, partner," or a "man's word is his bond." Personal honesty and integrity are basic American values that still permeate rural areas. Locking doors and not letting strangers in when they express a need, are contrary to their concept of being neighborly. And what do you suppose happens to an older farmer as he moves into an urban setting and finds that he can't trust people like he did on the farm.

8. Responsibility -- dependable, reliable
"As sure as the sun will rise tomorrow," or "as sure as God made little green apples." Rural values are based on a commitment made is a commitment that should be fulfilled. You could depend on your neighbor, or your senator. What happens if your neighbor in a high rise elderly complex isn't reliable or responsible? Might it be more difficult for an older rural value system to adjust to life in Topeka or even Kansas City in 1979? How do you suppose rising burglary and assault figures affect their perception of trust?

The rural aged has been accused of being rigid, inflexible and not bending in the wind and adjusting to their immediate best interests. Should the rural aged adjust their basic values to cope with a changed urban value system? Is this in the best interest of the nation and all individuals over 65? Rather than losing these values, perhaps a redirection of these basic judgement might benefit us all. If the older rural individual played an active role in the development and operation of programs designed to meet their needs, wouldn't we all benefit? Instead of the perceived "dole system," or giving something for nothing, reciprocal programming concepts could be explored. The examples of Foster Grandparents giving love, companionship and knowledge in exchange for financial and supportative service reward is one that affirms this concept. Federal programs are often developed around urban models, but many allow "grass root" input from self governing advisory boards. Because of the low density of population in rural areas, greater emphasis may need to be placed or real and surrogate family support systems and existing social agencies such as church, school and social services. Older rural individuals have an excellent opportunity to control their destiny by becoming involved on advisory boards, taking part in the upcoming 1981 White House Conference on Aging, writing to legislators and all sorts of advocacy roles. Because of their rural basic values judgements and knowledge of what works for them and the community at large, the lives of all older people might be enriched.

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SOCIAL GERONTOLOGY

UNIT #1
SOCIETAL STRUCTURE AND ITS RELATIONSHIP TO THE AGED (CS 311)

SESSION #3
PRIMARY RELATIONSHIPS: FAMILY, FRIENDS AND NEIGHBORS (CS 311-3)

Resource leaders: Lela Barns, retired musician and historian
Vivian Umbarger, Higher Education Act Title I project coordinator of Social Gerontology Workshops
Jeanne C. Tucker, Director, Gerontology Institute, Washburn University

Suggested Agenda

Introductory lecture: The Intimate Generation Gap

Video presentation: The New Definition of Family Maggie Kuhn

Lecture: Self-Concept Change in Later Years

Video presentation: Measure of My Days - An interview with Lela Barnes

Lecture and discussion: The unexpected community of new families, friends

Feedback and evaluation

Objectives of Session #3

1. Present materials relative to family roles as it relates to historical events and chronological age of the individual.
2. Present materials pertaining to the primary relationships of individual family members and the changes that occur as individuals age.
3. Present materials related to culturally biased views that exist in mid-western societal structures.
4. Present materials that relate to the nature and cause of intergenerational conflicts that exist in families.
5. Present materials that relate to the changing and inter-related roles of the parent/child as the child matures the structure becomes parent/adult child/child.
6. Discuss the potential roles and status of older individuals in later family life cycles.
7. Explore possible matching techniques of complex family needs of an older person and suitable and available needs meeting environments and services.

8. Discuss the role of the family, friends and neighbors of the older cohort group.

9. Offer opportunities to find and utilize relevant materials that pertain to family life cycle and the older individual.

10. Have available resource materials that would allow the participant to explore relevant local, regional and national data that responds to their particular area of concern.

Introductory Lecture

The Intimate Generation Gap

Family dymanics have changed considerably during this last century. Interpersonal relationships in families vary in terms of the degree of intimacy, both in emotional involvement and physical proximity. The self supporting large rural family, all living under one roof and sharing lifes joys and sorrows is no longer available to many urban individuals.

As we reminiscence back to the extended rural family cluster we can idealize those primary relationships. All generations lived in one housing arrangement, encouraging frequent contacts with grandparent, parent, children. An exchange of service was necessary to survive and cope with the challenge of "living off the land." Individuals within this family structure were involved in many roles: mother, daughter, grandmother, wife, aunt, sister, cousin on a daily basis.

A number of contemporary changes have influenced the constellation of these family roles. To begin with, the decline in mortality rates since 1900 has had the result of adding a fourth generation to many families - thus the position of great-grandmother, grant-aunt is much more evident in American family structures. Many of my cohorts are grandparents - and their grandparenting role is much different than the role model of their grandparents.

By looking at a hypothetical Kansas genealogy, we can explore some of the differences in primary and secondary family relationships and discover our own intimate generation gaps.

Blackboard chart discussion of four generation family. (see You Are What You Were When)

Conclusion

The value processing of each generation has of course affected our interpersonal relationships. The need for large families in the early 1900's, the depression of the 1930's, the awareness of the need for zero population growth in the 1970's have all impacted upon our value processing. Socialization is a lifelong process. We normally think of teaching the young, but what about the continued role of adapting to changes in society that older people are experiencing? The role models for grandparent and adult child somehow do not fit our life styles - and cause knowledge gaps in a much more intimate way - within ourselves.

Video Presentation: Over Easy/Hugh Downs interview with Maggie Kuhn

Maggie Kuhn discusses her "new family." Because her related family is gone, she has some young friends living with her and forming a new societal structure or a new family.

The Intimate Generation Gap
or
You are what you were when

Preparation: Either on blackboard or paper draw a large chart divided into equal ten year segments beginning in 1890-1990.

Lecture: The purpose of this illustrated lecture will be to illustrate the "intimate" (a personal) generation lineage and how each generation perceived historical events.

A. Unique family histories - each one different as snowflakes, but all build on one another.

1. Maternal grandmother

Born in 1870's - died 1935
Had ten brothers, sisters, half brothers and sisters
Father had two wives - first one died

Schooling - Grade school

Married - Scotch-Irishman from large Indiana family
He immigrated to Kansas and worked on their farm
As a young couple they moved to Ness County to homestead and farm

Children - Had nine children - four boys - five girls

Occupation - Housewife/practical nurse

Died - Heart attack in California after train overheated on way to California to visit youngest son

2. Mother

Born in 1910's - youngest of nine children
Father died when four years old
Lived with married sisters while her mother worked as practical nurse

Schooling - High school - business college

Married - German-English salesman

Children - One

Occupation - Executive secretary/housewife

3. Me

Born in 1930's - Only child

Schooling - College in 1950's - quit to become Mrs.
Returned to college in 1962 - graduated 1969
Masters degree 1978

Married - Before I could vote/divorced before thirty-five
Married second time on forty birthday

Children - one son, one daughter, two step daughters
one step granddaughter

Occupation - Gerontologist

4. Daughter

Born in 1950's - one brother, two step sisters

Schooling - BA in Psychology 1976

Marital - single

Occupation - free lance artist

Lecture: Self-Concept Change in Later Years

Youth was the time for searching
Trying to find one's self.
Attempting to know one's self.
Roaming in many directions to
find the answers.

With maturity the search ended.
The peace and quiet of standing still.
The friendship with one's self.
The acceptance of one's faults.
The knowledge of one's strengths.
And, thankfully and happily, the feeling
each morning of liking one's self.

June Polis

Human beings have the unique ability to think about themselves or self. The self can be defined by interpretation of feedback from within ourselves and from others. The self consists of two elements; the cognitive or self-concept, what you are like; and the emotional or self-esteem, how you feel about your self-concept.

One of the key factors in the development of self is the complement of social roles one plays. The roles of student, husband or wife, parent, church or civic club member, teacher, plumber, secretary, community leader, neighbor, friend, -- all have clearly defined expectations and behavior patterns, and all provide some degree of identity and self-concept.

Taking up a new role involves the stereotyped expectations of the society, but is also influenced by your own personal qualities and former experiences. Some of the new roles which older people often have to assume are widowhood, retirement from a career or job, illness and/or disability, dependence, living alone, institutional living, being a member of a group instead of the leader, a learner instead of teacher, etc. The United States has never identified a role for its older people, so we have no well defined behavior pattern for them. Not too many years ago, old implied mostly negative characteristics; not active, not working, not contributing to the family or society, not healthy, not involved, etc. Although there have been many changes in this attitute, we still do not have clear expectations for the new roles which older people have to assume. Thus our elderly must create their own life styles, and, in doing so, try to maintain satisfactory self-concepts and self-esteem.

How do self-concept and self-esteem change with age? Self-concept appears to be more dependent on inner orientation as we grow older. We tend to cling to earlier roles for our identity. Social interactions, understanding how we are perceived by others may or may not influence self-concept in the later years, depending on our need to alter it. Kenneth Woodward has said, "The main goals of healthy older people are to stay active and to feel good about themselves." It may be that staying active is not so important in itself, as is the fact that our society attaches so much importance to doing rather than being, and thus being active will help us to feel good about ourselves. In any case, much of the change in self-concept in the later years comes from the need to feel satisfied with ourselves. If earlier life experiences did not produce a satisfactory self-concept and it is perceived that our social environment does not quite approve of us, then we may make some effort to change. If, on the other hand, we achieved a high degree of satisfaction in self-concept in earlier experiences, the attitude of society may not matter Atchley says, "A good

definition of insecurity might be the inability to come to closure concerning one's self-concept." Some may reject the use of the word closure, believing that it precludes the desirable ability to change as we age.

Self-esteem is influenced by our inner feelings, our social roles and social interactions; but it is more volatile than self-concept and is subject to moods and bodily states. Atchley states that as people grow older, they tend to shift from seeing themselves as masters of their fates to being primarily responsive to other peoples' demands. How they react to this shift depends on their vision of the ideal. If they idealize the rugged individualist, the result of this shift on their self-esteem will probably be negative. If, on the other hand, they idealize accepting one's roles in life and playing them to the hilt, then the result could be positive.

Past role performances, if satisfactory to the individual, give some sense of identity and status. Bernice Neugarten states that the inner life becomes more important with age, cognitive processes decline, competence in role performance shows little or no change and an increasing separation from environment occurs.

Most of the studies tend to support the belief that self-concept usually remains stable in the later years, while self-esteem can be manipulated. Of significant importance, of course, is the diversity in personality types. In a study by Nuegarten and Havighurst in 1969 of men in six industrialized countries, one of the conclusions reads: "Certain personality types, as they age, slough off various role responsibilities with relative comfort and remain highly content with life. Other personalities show a drop in role and in social interaction and show a drop in life satisfaction. Still others have long shown low levels of activity accompanied by high satisfaction and show relatively little change as they age." This same study points out that patterns of personality organization reflect long-standing life styles and that consistencies rather than inconsistencies in coping styles predominate as an individual moves from middle age through old age.

Many role changes in later life represent a constriction of space, diminution of the number of positions, loss of close ties with family members or friends, thus being mostly negative. On the other hand, the role changes may provide time and opportunity for increased interest in public affairs, reading, leisure activity, community service, etc. and be perceived as positive.

The interview which you will see on video-tape now will point up some feelings held by a ninety-year old lady in regard to the losses she has sustained and the changes in her roles and life style. Here you will also see an example of adaptation to these changes by one whose personality type clearly determines the pattern of that adaptation. Lest the viewer believes that this subject is a woman of particular abilities not typical of many older persons, the interviewer agrees that she is a rather special lady who has made an adjustment better than most. However, she is an example of only one personality type, having lived and survived in her own special set of circumstances. Another person would demonstrate his or her own pattern of personality organization, although for purposes of this interview it was particularly helpful to have a subject who could be introspective and also very articulate.

Video Presentation

Measure of My Days

An interview with Lela Barnes

Mrs. Barnes was born in 1888 in North Dakota and early in her life showed a talent for music. She studied violin with the intention of pursuing a musical career, but was a victim of poliomyelitis in her early twenties and was never able to play the violin with the same degree of artistry as before her illness. This was a severe disappointment in her life, but she married and enjoyed music listening and limited performance on her violin.

When her marriage terminated, she lived for a short time with her family until she accepted a position with the Kansas Historical Society as manuscript reader. She held this position for many years, retiring from full time work at the age of 65, and continuing an independent project on a part-time basis until the age of 80. She has always maintained a high level of interest in music, art, and literature. She has also been keenly interested in politics, both national and international and has kept herself well informed on all of these subjects.

Failing health made it appear unwise to continue living alone so about ten years ago, Mrs. Barnes moved into a retirement center. She lives in a studio-apartment where she can prepare her meals and take care of her own personal needs as she wishes, but where she has access to a dining room, housekeeping services, laundry, and medical care if she needs them. She listens to music, reads as much as her vision permits, watches selected programs on the educational television network, and participates in a limited number of social activities within the retirement home.

Vivian Umbarger, the interviewer, was the Director of Social Services at the retirement center where Mrs. Barnes lived. Following Mrs. Umbarger's own retirement, a close personal friendship was maintained with Mrs. Barnes and they have enjoyed many mutual interests.

This interview is based on the book "A Measure of My Days" by Florida Scott-Maxwell.

The Measure of My Days, Florida Scott-Maxwell, Alfred A. Knopf, New York, 1978

Florida Pier Scott-Maxwell was born in Orange Park, Florida, on September 24, 1883. She had lessons at home until she was ten, briefly attended public school in Pittsburgh, then went back to private lessons, and finally gave it all up to go on the stage at sixteen. At twenty she abandoned that career and began another as a writer of short stories. In 1910 she married John Maxwell Scott-Maxwell and went to live in his native Scotland. Until 1935 she worked for women's suffrage, wrote plays and tended her flowers and children. In 1933 Mrs. Scott-Maxwell began training for still another career as an analytical psychologist, studying under C. G. Jung. Since then she has practiced in psychology clinics in Scotland and England.

At eighty-two Florida Scott-Maxwell felt impelled to write about her strong reactions to being old and to the time in which we live. She writes, "I was astonished to find how intensely one lives in one's eighties. The last years seemed a culmination and by concentrating on them one became more truly oneself. Though old, I felt full of potential life."

The territory of the old is not Mrs. Scott-Maxwell's only concern. In taking the measure of her days as a woman of the most disturbing conflicts of human nature, and her insights are challenging and illuminating.

The Interview

"Age is truly a time of heroic helplessness," said Mrs. Scott-Maxwell in the early pages of the book. Mrs. Barnes disagreed, saying, "I find nothing heroic about it, although I do deplore the degree of helplessness which comes with old age and its disabilities." She believes that it is possible -- and desirable -- to accept whatever disability comes, to seek and utilize every kind of aid available, and then to concentrate on the abilities that remain. She sees this a pragmatic approach, and prefers it to the "heroic" which she rejects as passive submission or the "martyr complex."

"One is confronted by one's own incorrigibility, I still have the vices that I have known and struggled with since birth....my faults are stronger than I am." Mrs. Barnes agreed with this statement, pointing out that many of the faults and lacks which she had in earlier years are still a part of her character in old age. "I have never accepted the idea that we 'mellow' with age; one does not become a benign, sweet old lady in the later years if she was not that kind of person in her earlier years."

"Life still interests and occupies me--please God, may I die before I lose my independence." The changes in her life which bother her the most are the physical limitations and the social environment which keep her from functioning as a contributing member of society. She greatly misses the work which she did at the historical society and the people whom she came to know there. She feels that she achieved an identity as a person which she greatly misses. She makes an effort to keep herself informed about what is going on in the world and continues to enjoy great music and literature. She added that one thing which bothers her the most at this stage of her life is the lack of stimulating conversation, and the inability to seek out people who enjoy thinking and talking in depth.

Regarding the desire to maintain independence, Mrs. Barnes reminded the interviewer of the statement by Mrs. Scott-Maxwell that "Independence comes in the knowledge that there is no need to bother about a lot of things." She agrees that there is a kind of joy and relief in knowing that many of the things which formerly took much time and energy now seem relatively unimportant. She suggested that older people no longer need to worry about what others may think or say in regard to your behavior, and this provides a source of independence. "I enjoy the freedom to speak out and say what I please, without too much concern about what someone else thinks." Although her physical condition has made it necessary to live in the supportive setting of a retirement home, Mrs. Barnes denied that this in itself had caused her to lose her independence.

"The woman who has a gift for old age is the woman who delights in comfort." Mrs. Scott-Maxwell made this statement in writing about the increased amount of time and energy which she must expend in taking care of her bodily comfort. She therorizes that since this is truly necessary, one has a real gift for becoming old if one can just enjoy being comfortable. Mrs. Barnes agreed, saying that she would not have believed in her earlier years that she would ever be so pre-occupied with creature comforts. It has become very important to her to continue being well groomed, warm, and to have good food. She expressed great satisfaction with the retirement home where she lives in its supportive services for these facets of her life.

"Life does not accommodate you. It shatters you -- it is meant to, for only when the seed is shattered does the life within come to fruition." Mrs. Barnes agreed with this idea for the most part, although she was reluctant to accept the inevitability of the process, believing that the individual has some control over his life--even in the later years when dealing with role changes and changes in self-concept. She said, "one must not accept the shattering experiences in life as an end to living, but must actively seek for ways to move out of them into some kind of fruition." She mentioned, at this point, the early disappointments in her life and the satisfaction she had found in her career as a manuscript reader for the historical society. Although she misses the actual work and the contacts she made, she still feels a great measure of self-esteem from the skills which she developed.

Mrs. Barnes mentioned the segment of the book which questions the ardent search for equality and speaks of the need to maintain "that precious difference of the individual...Anyone who has become himself will respect himself for his difference and so be respected by all." Mrs. Barnes agreed with the author's discussion of the cry for an egalitarian society as opposed to the gains to the society resulting from our differences. She pointed out that much good can come from greater equality of circumstances, but that there is danger in living at a collective, depersonalized level, never fulfilling the potentials which are there because of our differences. She agrees with the author that too much energy may have been expended upon the search for equality, and not enough upon maintaining the precious difference "which gives to each of us a self-concept and an individuality even in old age."

"We old people are not in the modern life; our impressions are second or third hand--we do not really know its effect upon us." Mrs. Barnes could not agree with this concept and said that aside from mental impairment or indifference, one need not be dependent upon second hand impressions. She mentioned this television interview as one aspect of modern technology which she was most happy to enjoy. She has the desire to reach out and understand, if not actually participate in, as much of today's world as possible. As an example of her ability to accept new ideas as a part of the modern life, she told of a young relative who had recently gone on a two-week trip with her boy-friend. Said Mrs. Barnes, "I thought about the new morals and standards of the time, and while I did not wholly approve of the incident, I didn't go into a decline over it!"

"No one lives all of the life of which he was capable. The unlived life in each of us must be the future of humanity." In a poignant, deeply philosophical section of her book, Mrs. Scott-Maxwell continues, "When truly old, too frail to use the vigor that pulses in us, and weary, sometimes even scornful of what can seem the pointless activity of mankind, we may sink down to some deeper level and find a new supply of life that amazes us...that tiresomely rigid person we supposed ourselves to be stretches, expands, and with all inhibitions gone, we realize that age is not failure nor disgrace...further on, one finds that one has arrived at a larger place, a place of release, and we know with clear conviction that there is more to us than age."

Mrs. Barnes and the interviewer agreed that this was a beautiful statement from one who has been able to come to terms with the changes brought about by the aging process. Coming to such a conclusion about life enables one to enjoy a sense of freedom from earlier demands, a certainty of gains as well as losses, and a feeling as Scott-Maxwell puts it, "I serve life, certain that it is the human soul that discerns the spirit, and that we are creators."

Lecture and Group Discussion

The Unexpected Community of Friends and Families

Arlie Russell Hochschild has written a book entitled The Unexpected Community that explores this new social living alternative of age separated housing or the elderly high rise concept. As Miss Hochschild states in the preface of her book, there are several reasons that this is a subject of interest to social gerontologists. First, there is the interest in old age, our own, our parents and other peoples. Second, there is the concern for old age as a social problem.

This book is mainly about a group of forty-three people who live in a small apartment building near the shore of San Francisco Bay, but it can easily be related to similar communities of old people in Kansas.

Miss Hochschild is a sociology professor and this book is a sociological study of the interpersonal relationships that she found in this unexpected community of older people living in the same geographic space. Her book describes the relationships as "a pool of models for growing old, as a sanctuary and as a subculture with its own customs, gossip and humor."

The book goes into homely details about such things as the furnishing in living rooms and how the placement of the windows and furniture affected the social structure. She included the contents of refrigerators as social indicators of their rural backgrounds of food preparation and sharing. But, it also clearly illustrates how primary relationships can develop within a cohort group and be supportative of the family primary relationships, rather than distracting. Aging myths exist that older people are lonely, isolated and neglected by their families. This study underscored that most older people still have daily, or frequent contact with family members, and the support of their own age group.

Discussion Points

1. Gaining the trust of the older person
   Miss Hochschild worked for three years as an assistant recreation director. She had time to establish interpersonal relationships before she identified herself as a sociologist. The residents would have been highly suspicious of a sociologist who asked permission to question them for three or four hours and then disappeared. The older residents do not ask one another personal questions, and consider it impolite to pry. By taking part in the rituals of daily living, she was able to observe the interrelationships in a natural time and order. Structured needs assessment questionaires often are not able to accomplish this kind of indepth, sensitive analysis.

2. Intergration vs separation
   One of the trigger questions of the 1971 White House Conference on Aging centered on the choice of housing alternatives. The unexpected community gives credibility to the support that older people, who are no longer in the work force, substain by living in age separated housing. Mutual values and common daily experiences seemed to encourage social interactions and support.

3. Work vs leisure
   The recreation director in this setting was able to motivate the older women to make items to sell at the annual bazaar. This activity was viewed as work, as they joked about "putting in their time." Individuals were able to take part in group creative crafts if there was a tie-in with their mid-western, rural, Protestant work ethic value system.

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SOCIAL GERONTOLOGY

UNIT #1
SOCIETAL STRUCTURE AND ITS RELATIONSHIP TO THE AGED (CS 311)

SESSION #4
GERONTOLOGY: GETTING BETTER ALL THE TIME (CS 311-D)

Resource leader: Jeanne C. Tucker, Director
Gerontology Institute, Washburn University of Topeka
Vivian C. Umbarger

Suggested Agenda

Introductory lecture: Is there a gerontologist in the house?

Group discussion & exercise: Where is gerontology today?

Lecture: How successful is pre-retirement education?

Group discussion: What resources are available in social gerontology programming?

Feedback & evaluation

Objectives of session #4

1. Discuss the rapid growth of gerontology in academic programs.
2. Discuss the multidisciplinary perspective of gerontology.
3. Present materials describing selected gerontology centers & institutes in the United States.
4. Present a variety of curriculum, workshop schedules and publications that are offered by the field of social gerontology.
5. Discuss possible careers in gerontology.
6. Discuss the value of research in social gerontology.
7. Discuss the past and future implications of pre-retirement education.
8. Discuss the linkages between academic training in gerontology and working professionally with older people.

Introductory Lecture

Is There a Gerontologist in the House?

What is a gerontologist? This question has recently been asked at professional meetings of various disciplines. Does this title apply to:

1) A researcher involved in the study of the aging process?

2) A teacher imparting knowledge about gerontology?

3) A program developer designing social services to meet the needs of older individuals?

4) An older person serving on advisory committees and advocating for the needs of the elderly?

5) An administrator managing a retirement home facility?

6) A nurse interested in holistic health care for older individuals?

7) A human relation expert exploring interpersonal needs of older individuals?

8) A psychiatrist counseling an older person in time of stress because of multiple losses in old age?

9) A minister offering spiritual guidance to individuals as they near death?

10) An interested individual studying their own aging concepts an processes?

There may be no clear cut answer - or - several people may be qualified to stand as they as asked To Tell the Truth, "Will the real gerontologist please stand up?" By looking at three recent articles by gerontologist from different disciplines and locations, perhaps we can extract some of the essence of this confused terminology.

Duke University for the Study of Aging and Human Development, George Maddox, Director, Center for the Study of Aging and Human Development and Professor of Sociology and Medical Sociology.

> Aging is universal. We all do it everyday. There should be a broad spectrum of interests that are involved. Specialized fields such as psychology, sociology, economics, political science, nursing, medicine, social work, human relations, all have legitimate claims in gerontology. Because aging is so complex, perhaps anyone who is genuinely interested and devotes time to gerontology - could be called a gerontologist.

Ethel Percy Andrus Center on Aging, Dr. James Birren, Executive Director, Andrus Gerontology Center and Dean Leonard Davis School of Gerontology.

> There should be academic programs developed leading to baccalaureate degrees and master's degrees in gerontology, but no doctorate programs. Because gerontology is so complex, intense research on the doctorate level in gerontology is almost impossible. Interested candidates need to choose a discipline, such as sociology, nursing, psychology, etc. to focus their in depth studies, with a special emphasis in gerontology.

Wichita State University, Dr. William Hays, Director, Gerontology Center and Sociology Professor.

Because of the change in the population components, the political power of older people and the federal programs designed to meet the needs of older people, perhaps there is a need for someone with training in the specifics of gerontology. Individuals currently working with older people and administering the Older American Act programs are requesting academic gerontology courses be offered for college credit. Older people are returning to campus and younger students have shown increasing concern for educational opportunities in gerontology. Perhaps a quote from one of his younger students sums up one major reason for this rising tide of interest. "The study of gerontology is an investment in my own future."

Group Discussion and Exercise

Where is Gerontology Today?

Procedure:

Resource tables displaying resources from four or five established gerontology centers are arranged around the room. Descriptive signs and poster should clearly identify the institution on display.

Brief descriptions of the resources should be made to introduce the participant to the emphasis or special resource of each institution.

Ample time should be allowed for the student to examine the materials and make notes for future reference.

As group reconvenes, discuss the diversity and depth of resource appearing in the field of gerontology in last ten years.

Suggested resources:

Ethel Percy Andrus Gerontology Center, University of Southern California, University Park, Los Aneles, California 90007.

Summer Institute for Study in Gerontology

Two week courses covering the many dimensions of aging are conducted in four sessions during the summer. The two week seminars are offered either for two hours of academic credit or for thirty hours of continuing education units. To further enhance the Summer Institute experience, a variety of additional features are provided:

Film Festivals are conducted weekly to offer opportunities for exposure to current gerontological media

Special lectures are held by faculty and invited guests on a variety of timely gerontological topics.

Field trips are arranged each session to nutrition sites, nursing homes, senior centers and other gerontological facilities.

Social events are organized to provide a forum for the exchange of ideas and resources among participants and faculty in an informal setting.

Both undergraduate and graduate courses are offered. Admission to the Summer Institute is on a competitive basic.

Leonard Davis School of Gerontology, Andrus Gerontology Center, University of Southern California.

At the Andrus Center, research in the biological and social sciences is providing new insights into the aging process and the behavior of older people. This research has made it possible to better understand the needs of older people and to develop programs and services for them. The facilities of the center and valuable resources for the Leonard Davis School of Gerontology which offers educational programs at the following levels: 1) Bachelor of Science in Gerontology 2) Master of Science in Gerontology 3) a Certificate program

of the center and valuable resources for the Leonard Davis School of Gerontology which offers educational programs at the following levels: 1) Bachelor of Science in Gerontology 2) Master of Science in Gerontology 3) a Certificate program for people who already have a professional degree and experience in gerontology.

Programs leading to dual Masters degrees are available with other professional schools so that students can meet the requirements for Master's degrees in two disciplines within a twenty four month period.

The Center publishes many books and monographs on various aspects of aging and program planning. A Pre-retirement program has been developed and has been widely used by business and industry as well as in academic settings. A series of nine technical bibliographies on such concerns as Environmental Planning, Relation of Stress and Age, Sexuality and Aging and Intellectual Functioning are also available. A list of publications may be ordered from Richard H. Davis, Ph.D., Publications Office, Andrus Gerontology Center.

New England Gerontology Center, New England Center for Continuing Education, University of New Hampshire, 15 Garrison Avenue, Durham, New Hampshire 03824.

Although this center offers institutes and classes for professionals, a major emphasis is placed on programming older adult learning experiences. The Elderhostel program is one of the outcomes of their programming. The Center designed a summer learning experience, that brought older adults to live in their dormitories for a one to two week period and take part in special classes on their campus. The classes were designed for fulfillment and enjoyment, not to train gerontologists about the subject of aging. The ideal has spread across the nation and presently over 1,000 locations are available for summer Elderhosteling.

Gerontopics, is published nine times yearly and highlights special topics related to aging, such as crime prevention, the rural elderly, educational opportunities, etc.

Duke University for the Study of Aging and Human Development, Box 3003, Duke University Medical Center, Durham, North Carolina 27710.

Research, training and information dissemination are major focuses of this center. Because of the connection with Duke Medical School, significant research has been done in geriatric medicine.

A major resource is KWIC (Keyword Indexed Collection) this comprehensive service includes extensive listing of available resoruces. By choosing a key word - such as pre-retirement education programs - a listing of training resources c

be made available. The Center collects, screens and indexes materials suitable for trainers, researchers and older persons. ASTRA (Analysis and Selection of Training Resources on **Aging**) is available for a small fee - as are several KWIC publications.

Western Gerontological Society, 785 Market Street, Suite 1114, San Francisco, California 94103.

A multidiscipline organization which provides training conferences (such as the annual meeting) technical assistance, advocacy, information services regarding training opportunities, resource leaders, printed materials. Their list of publications include reports of their annual meetings, which often cover three hundred topics and Generations, the quarterly newsletter.

Kansas State University, The Center for Aging, 239 Waters Hall, Manhattan, Kansas 66506.

The Centers' activities are in large measure carried out by three committees - Education, Research and Outreach. It coordinates and develops educational and training programs on aging, stimulates aging research, coordinates outreach activities and serves as a referral center for information on aging problems and resources in Kansas. As a land grant university, KSU has a special mandate to serve the rural area and smaller communities in Kansas.

University of Kansas, Gerontology Center, 211 Fraser Hall, Lawrence, Kansas 66045.

The Center has as its purpose "to stimulate and integrate activities at the University of Kansas that are relevant to adult development and aging." It coordinates a graduate concentration in aging in the School of Social Welfare, encourages faculty research and develops continuing education opportunities. The KU Medical Center and the Gerontology Center work closely together to develop training in geriatric medicine for nurses and all those interested in medical training.

Washburn University, Gerontology Institute, Benton Conference Center, Topeka, Kansas 66621.

The WUGI offers professional workshops for adult care home personnel, social workers, nurses and the aging network. It also provides a focus on and identification for the increasing University involvement in gerontology. Coordinating curriculum development for the professional and the older adult in multidisciplinary departments is a common objective shared by most universities in Kansas. WUGI also responds to community imput regarding training needs in the field of gerontolgoy.

Wichita State University, Gerontology Center, Wichita, Kansas 67208.

The only University in the state to offer a Master's degree program in Gerontology, either as a generalist or a specialist. A baccalaureate degree may be obtained with either a major or minor in gerontology.

The Center also develops and manages community research in the area of aging and serves as a resource center and information clearing house. The Gerontology Center newsletter is published bi-monthly.

Many other colleges in the state offer gerontology credit courses, sponsor conferences of interest to gerontologist and provide educational opportunities for older adults. Coordination with professionals and agency training needs are two of the major objectives that all Kansas schools are striving to fulfill.

Lecture

How Successful is Pre-Retirement Education?

The Washburn University pre-retirement planning course is an example of a local community university programming to respond to a community need. The course variously titled through the years Toward Successful Retirement, Keys to Planning Your Future and Good Years Ahead met the need for pre-retirement planning in various ways.

It was first offered at Washburn University in 1961, before many organizations had designed a program for pre-retirement planning. Few, if any, guidelines were available to follow, and the course grew to fit the occasion. Washburn University worked in concert with the State Department on Aging (then the Division of Services to the Aging, Department of Social Welfare) and various professionals and university personnel to put together a series of lectures to aid an individual plan for his retirement.

The first few years, most of the participants were in their sixties or late fifties. The course was advertised in the newspaper, so the participants came from all sorts of professional and non-professional backgrounds. Gradually the average age of the participants became younger, with more and more people in their forties and fifties attending. If the participant was married, the spouse was encouraged to attend the sessions and be a part of the pre-retirement planning.

Originally, the course consisted of from six to ten sessions of two hours each. The session dealt with health, housing, money management, social security, psychological adjustment, legal concerns and use of leisure time. As participants started the sessions, questionaires revealed they were most concerned with financial planning - but - in the final evaluations, most participants gave priority rating to emotional adjustment to the retired role.

During the first session it was made clear that there was no "blue print" for planning retirement. The philosophy was "we don't know the answers for your individual retirement planning, but we do know the questions you should be asking." The objectives of the course were 1) to stimulate early planning for successful retirement 2) to raise the questions that should be asked and 3) suggest options and resources for finding the individualized answer.

Outside speakers were invited to deal with various topics, but the discussion by participants was always an important element of the learning experience.

The planning course was offered in various settings. On the University campus at night, and for two years, on the premises of several business firms. Conferences were held to appeal to a larger number of individuals and a manual was produced to be used by the individual in pre-retirement planning titled "Good Years Ahead."

In evaluating the pre-retirement program in terms of its success, these facts emerged:

1) The program appeared to meet a need in the community since there continued to be participants year after year.

2) Evaluation instruments administered to class members at the close of each program indicated that they had found it helpful and that they had been stimulated to continue planning for their own successful retirement.

3) A study of professional and educational backgrounds of class participants indicated that the program was reaching a select group of people. Individuals who were already raising some questions about retirement and were "ready" for this kind of learning experience. Studies were undertaken as to how to reach the blue collar worker who, for various reasons, was reluctant to deal with the idea of retirement, particularly on a college campus. In an effort to expand the target group, the course was adapted for presentation in local business firms or on their own turf, with the companies allowing an hour of work time and the participant using one hour of their own time.

Washburn University has continued to be interested in Pre-retirement education by providing assistance to groups in planning such programs, as consultants or in actual staff participation, and by providing audio visual and written materials. The fact that pre-retirement programs are being developed by diverse groups such as churches, libraries, small business firms, and continuing education programs seems to indicate that the earlier attempts created an awareness of the importance of pre-retirement planning.

Hopefully, the acceptance of retirement as a phase of the total life cycle will become a part of the curriculum in any discipline that deals with self awareness. Indeed, the long range goals should be to establish an awareness of this phenomenon in our secondary and even elementary schools, so that individuals could be involved in informal planning starting at an early stage of life and continuing into a fulfilling and succesful retirement period.

Pre-retirement Planning Model at Duke University Center for the Study of Aging and Human Development.

In answer to the question "How successful is Pre-retirement?" it would be of interest to consider an experiment at Duke University in which a model program was developed and tested. A carefully selected group of participants was matched with an equal number of control subjects who did not have the pre-retirement training. Was adjustment to retirement affected by participation in the training course? Adjustment to retirement was defined as an adaptation which results in good health, personal satisfaction, social integration, active and productive leisure. Eight measures of adjustment were used to compare the two groups.

When scores on these measures before and after retirement were compared there was evidence of substantially better adjustment among the groups who had the training program than among the control group. Statistically significant evidence of better adjustment by the program group was found in each of four areas of health, life satisfaction, social integration, and both active and productive leisure.

Group Exercise

What Resources are Available in Social Gerontology Programming?

Procedure: Resource library set up for participants

Suggested resources: Magazines and professional publications

Aging, AoA, DHEW, Washington, D. C. 20201

Best Years, National Association of Mature Persons, Box 26245, Oklahoma City, Oklahoma 73126

Dynamic Maturity, Action for Independent Maturity, AARP, 1909 K Street NW, Washington, D. C. 20049

Educational Gerontology, an International Quarterly, Hemisphere Publishing Crp., 1025 Vermont Ave. NW, Washington, D.C. 20005

50 Plus, formerly Retired Living Magazine, 99 Garden Street, Marion, Ohio 43302

The Gerontologist, For Professionals Who Keep Abreast of New Developments in the Aging Field, Gerontological Society, #1 Dupont Circle, Washington, D. C. 20036

Modern Maturity, American Association of Retired Persons, 215 Long Beach Blvd., Long Beach, California 90801

NRTA Journal, National Retired Teachers Association, 1909 K Street NW, Washington, D. C. 20049

Perspective on Aging, National Council on Aging, 1828 L Street, NW, Washington, D. C. 20036

Retirement Life for Federal Retirees, National Association of Retired Federal Employees, 1533 New Hampshire Avenue NW, Washington, D. C. 20036

Zantia, Stories and Poems by the Over-Sixty, P. O. Box 149, Annapolis, Md. 21404

Social Gerontology Textbooks

Atchley, Robert. Social Forces in Later Life, An Introduction to Social Gerontology, Second Edition, Wadsworth, 1977

Atchley & Seltzer. The Sociology of Aging: Selected Readings, Wadsworth, 1976

Barrow & Smith. Aging, Ageism and Society, Wadsworth Publishing Co., 1979

Barry & Wingrave. Let's Learn About Aging, A Book of Readings, Schenkman Publishing Co., Inc., 1977

Binstock & Shanas. Handbook of Aging and the Social Sciences, Van Nordstrand Reinhold Co., 1976

Gubrium, Jaber. The Myth of the Golden Years, A Socio-Environmental Theory of Aging, Charles C. Thomas, 1973

Kart & Manard. Aging in America, Readings on Social Gerontology, 1976

Tibbitts & Donahue. Aging in Today's Society, Prentice-Hall, Inc., 1960

Woodruff & Barren. Aging, Scientific Perspective and Social Issues, D. Van Norstrand Co., 1975

Zaret, Steven. Readings in Aging and Death: Contemporary Perspectives, Harper and Row, 1978

Education and Training Resources

AoA, Education and Training in Aging, A Practical Guide for Professionals, Proceedings and Final Report of Region VII Synopsis for Trainers in Aging, 1975

AoA, Project Idea, Directory, Innovative Developments in Aging, Vol I & II, 1977 and 1978

Cox, Harold. Focus, Aging, Annual Editions, The Duskin Publishing Group, Inc. 1978

Murphy and Florio. Never Too Old to Teach, Academy for Educational Development, 1978

National Council on Aging, Fact Book on Aging, A Profile of America's Older People, Academy for Educational Development, 1978

Scanlon, John. How to Plan a College Program for Older People, Academy for Educational Development, 1978

Seltzer, Sterns and Heckey. Gerontology in Higher Education, Perspectives and Issues, Wadsworth Publishing Co. 1978

Western Gerontological Society, Aging - Taking a Giant Step Forward, 24th Annual Meeting, 1978

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Barron, Milton, The Aging American: an introduction to social gerontology and geriatrics, Crowell, New York, 1961.

Bengston, Vern, The Social Psychology of Aging, Bobbs-Merrill, New York, 1973.

Birren, James, "Research on aging: a frontier of science and social gain," Readings in Gerontology, Brantl and Brown(eds), C.V. Mosby Co., St. Louis, 1973.

Duncan, Kenneth J., "Modern society's attitude toward aging." Geriatrics, v. 18, August , 1963, p. 629-635.

Gilbert, Jeanne, Understanding Old Age, Ronald Press, New York, 1952.

Havighurst, Robert J. and Albrecht, Ruth, Older People, Longmans, New York, 1953.

Shock, Nathan W., Trends in Gerontology, 2nd edition, Stanford University Press, 1957.

Shock, Nathan W., "Age With a Future," Reading in Gerontology, Brantl and Brown (eds), C.V. Mosby Co., St. Louis, 1973.

Spencer, Marian and Dorr, Caroline, Understanding Aging: A Multidisciplinary Approach, Appletone-Century Crofts, New York, 1975.

Tibbitts, Clark, (ed) Handbook of Social Gerontology: Societal Aspects of Aging, University of Chicago Press, 1960.

Vedder, Clyde, (ed), Gerontology, a Book of Readings, Thomas, Springfield, Ill.

Woodruff, Diana, "Introduction, Multidisciplinary Perspectives of Aging," Aging, Scientific Perspectives and Social Issues, Woodruff and Birren(eds), Andrus Gerontology Center, Van Norstrand Co., 1975.

Zarit, Steven H., Readings in Aging and Death: Contemporary Perspectives, Harper and Row, New York, 1978.

Birren, J.E., (ed), "Principles of Research on Aging," Handbook of aging the and the Individual, University of Chicago Press, 1959

Birren, James and Clayton, Vivian, "History of Gerontology," Aging Scientific Perspectives and Social Issues, Woodruff and Birren(eds), Andrus Gerontology Center, Van Norstrand Co., 1975.

Gerontological Mental Health

Washburn University Gerontology Institute

SOCIAL GERONTOLOGY

UNIT #2
GERONTOLOGICAL MENTAL HEALTH

SESSION #5
RECOGNITION AND MANAGEMENT OF GRIEF (CS 312-A)

Resource leaders: Pastor Bud Cooper, Minister, Countryside United Methodist Church, Topeka
The Reverend Milton Vogel, retired Methodist Minister
Jeanne C. Tucker, Director, Gerontology Institute, Washburn University

Suggested Agenda

Introductory lecture:	What losses do we experience as we age?
Group exercise:	Experiencing sensory losses.
Lecture/group discussion:	What is the difference between bereavement, grief and mourning?
Film:	Minnie Remembers - The Death of a Gandy Dancer.
Group discussion:	How can we be effective in helping others deal with grief?

Objectives of session #5

1. Develop an awareness for the need for a basic awareness of gerontological mental health.
2. Discuss the need to constructively cope with the mental health problems of the aged.
3. Present relevant mental health literature and films that relate to mental health in the middle and later life cycles.
4. Discuss possible community and individual responses to the mental health needs of older individuals.
5. Discuss losses that cause grief symptoms in older persons.
6. Discuss grief behavior of older persons.
7. Explore the difference between bereavement, grief and mourning.
8. Discuss and experience certain sensory losses that occur as we age.

Introductory Lecture

What Losses Do We Experience As We Age?

Introduction:

A. Scope and limitations of workshop:
   1. Cannot attempt to deal with grief management in depth.
   2. Cannot respond to personal grief needs.
   3. Objectives will attempt to:
      a) Identify different causes for grief.
      b) Explore some of the ways individuals express grief.
      c) Discuss some grief behavior coping mechanisms.
      d) Present resources and materials that are available to assist individuals study the subject further.

Dealing with Grief:

A. Multiple losses can add to the stress as one ages.
B. Each individual is unique - there is no ideal role model for grief behavior and management.
C. Individual personality, culture, socialization, and many outside factors, all affect coping capacity of grief management.

Our Grief Behavior Over Aging Losses:

A. Anger - hostility toward family, friends, "the world".
B. Denial - "How are you?" "I'm fine." "Are you all right?" "The roof needs fixing."
C. Withdrawal - individual and societal disengagement.

What Are the Losses?

A. Loss of significant person by death.
B. Anticipated loss of one's own life.
C. Anticipated or actual loss of a bodily function, such as sight, hearing and organ.
D. Loss of youthful vigor or physical beauty.
E. Loss of vocation or professional position.
F. Loss of social, economic or political status.
G. Loss of interpersonal functions with mature children (empty nest).
H. Loss of significant possession, such as a home.

The Social Readjustment Rating Scale:

A. How it affects you.
B. How it affects an older person.
C. Scoring and chances for health changes.

Using the Rating Scale:

A. Select the life events that you are presently experiencing.
B. Add the mean values together for your stress total.
C. If score is under 150 - great.
   If over 300 - be careful.

THE SOCIAL READJUSTMENT RATING SCALE AS IT AFFECTS OLDER PERSONS

Life Event		Mean Value
1.	Death of spouse	100
2.	Divorce	73
3.	Marital separation	65
4.	Jail term	63
5.	Death of close family member	63
6.	Personal injury or illness	53
7.	Marriage	50
8.	Fired at work	47
9.	Marital reconciliation	45
10.	Retirement	45
11.	Change in health of family member	44
12.	Pregnancy	40
13.	Sex difficulties	39
14.	Gain of new family member	39
15.	Business readjustment	39
16.	Change in financial state	38
17.	Death of close friend	37
18.	Change to different line of work	36
19.	Change in number of arguments with spouse	35
20.	Mortgage over $10,000	31
21.	Foreclosure of mortgage or loan	30
22.	Change in responsibilities at work	29
23.	Son or daughter leaving home	29
24.	Trouble with in-laws	29
25.	Outstanding personal achievement	28
26.	Wife begin or stop work	26
27.	Begin or end school	26
28.	Change in living conditions	25
29.	Revision of personal habits	24
30.	Trouble with boss	23
31.	Change in work hours or conditions	20
32.	Change in residence	20
33.	Change in schools	20
34.	Change in recreation	19
35.	Change in church activities	19
36.	Change in social activities	18
37.	Mortgage or loan less than $10,000	17
38.	Change in sleeping habits	16
39.	Change in number of family get-togethers	15
40.	Change in eating habits	15
41.	Vacation	13
42.	Christmas	12
43.	Minor violations of the law	11

Scoring		
	150 points	pretty safe ground
	150 - 300	chances 50-50
	300 +	pay up your health insurance

Group Exercise

Experiencing Sensory Losses

Points to remember:

1. Sensory losses and changes in older individuals are gradual - they rarely occur suddenly except in the case of an accident or serious illness.

2. As we age, we often experience multiple sensory losses.

3. Multiple losses are more difficult to cope with than a single loss.

4. Older people appear to have a capacity to cope and develop compensatory mechanisms to adapt to the sensory change.

5. Those interacting with an older person who understands these changes can help support his self image and cope with his environment.

Exercise:

Opposite handwriting - how do we adjust, react to change?
Equipment - paper and bold writing pen.
Members of the audience are asked to transfer the pen from the hand with which they usually write to the other hand and write for three to five minutes with an emphasis on their thoughts or feelings about having to write wrong handed.
Discuss reactions - Frustration, hostility, anxiety, adaptation.
Typical comments and reactions -

1. Extreme concentration - a determined writing of name and vital data and adaptations to the change.
2. Giggling and stating that it can't be done.
3. Looking around the room to see if others are doing better than you.
4. Adapting to printing rather than cursive writing.
5. Realization that if had more practice could probably improve.

Summary:

We seldom think about our handwriting skill since we acquire the skill early in life and use it habitually. Yet, even the loss of this simple skill can be painful, difficult, frustrating and arduous.

Other sensory losses:

1. Auditory or hearing -- potentially the most problematic of the perceptual impairments. Hearing loss can lead to suspiciousness and paranoia as hearing distorts sounds and loses other sounds. Older individuals may be labeled senile or irrational as a result of inattention, when in fact, they simply do not hear the interaction. Individuals seldom hesitate to wear eyeglasses or dentures, but somehow resist wearing a hearing aid as visible sign of their aging. The connection between hearing loss and depression has been definitely established.

2. Visual -- vision may become dim, distorted, blurred, or even completely lost. This loss brings with it loss of reading, viewing television, writing, familiar association with others and a sense of dependency. Visual loss can cause a decreasing amount of mobility, poor orientation and frightening visual impressions that resemble hallucinations. Older people feel more vulnerable to danger and crime when handicapped by visual and other sensory losses.

3. Taste -- taste buds atrophy and it becomes difficult to distinguish sweet, sour, saltly and bitter foods. Complaints about food among older individuals rise sharply, and this may lead to a decline in appetite and subsequent nutritional problems. Compensating behavior of salting and sweeting food can cause complications and health problems in high blood pressure and diabetes.

4. Olfactory or smell -- the sense of smell often diminishes in the later years and with it the ability to enjoy food and warning signals that could come from burning objects. The older individual may appear offensive in odor, both personal and environmental, because he is not able to identify the smell that is offensive to others. This may lead to withdrawal as well as rejection of society of the older individual.

5. Tactile or touch -- the loss of touch or thermal perception, making an older person susceptible to burns and not responding to injury or disease cues because of lack of pain. The importance of physical touch has beer research over and over, and because an older individual may be sterotyped as physically unattractive, other individuals may avoid any physical contact. Tools for communication through touch are exercise, massage, handshaking, handholding, a hug, a helping arm or hand, putting your hand on an arm or shoulder as one begins to speak, etc.

6. Kinesthesia -- or our spatial sensations and perceptions. Muscle strength and muscle sense change and more exertion is needed to grip or handle objects. The sense of balance may be less secure and an older person may complain of dizziness and a buzzing in the ear. Some may suffer from nystagmus, a constant involuntary cyclical movement of the eyeball, that causes an older person to perceive the floor moving up and down. The older person may compensate by walking widebases and in a slow shuffle, and be perceived by others as doddering and feeble.

Summary:

Despite profound losses of aging, the older person has remarkable resilience and ability to cope and adapt. If the professionals working with older individuals understand aging losses and are able to empathize, an older individual may be able to function with a greater degree of independence and self satisfaction.

Lecture/Group Discussion

What is the Difference Between Bereavement, Grief and Mourning?

Group brainstorming: Name losses that could cause feeling of grief and list them.
The list might include:

1. Retirement - loss of a occupational role
2. Widowhood - loss of a significant role
3. Divorce - loss of a significant role
4. Loss of health - loss of independence
5. Leaving home - loss of familiar environment
6. Empty nest - loss of family role
7. Assassination of a president - societal loss

As the group brainstorms let a simple list grow and fill in the type of loss later, as the group seems to feel the list is adequate.

Facets of the grief process:

1. Bereavement is the event - bereave's literal meaning is to deprive of (life or hope).
   Common expression "I'm sorry about your recent loss or bereavement."
2. Grief is the emotion connected with the event. It is described as intense mental anguish or acute sorrow.
3. Mourning is grief work - or the action or expression of one who has suffered a bereavement.

Culture and grief: Name the common responses to visible signs of mourning. "Don't cry," "Don't worry," "Keep your chin up," "Every cloud has a silver lining," "It was the Lord's will."

Physical symptoms of grief include:

1. Lethargy
2. Nausea
3. Loss of appetite
4. Loss of muscular power
5. Tight chest and breathing difficulty
6. Unnatural calm, dazed expression
7. Hysteria, uncontrollable crying or laughing

The stages of grief:

1. Shock - a numbness - The emotions refuse to accept reality. "No, not me or why me?" A denial takes place that must be accepted to continue healthy grief work.
2. Disorganization - confusion - The individual feels out of touch with the ordinary world. They may express surprise that the sun is still shinning and the birds are still singing, for their world is dark and full of despair.
3. Volatile emotions - terror, anger and resentment. The shocked "Why me?" Anger may be directed in many directions. Society often is shocked by these explosive expressions and may not be helpful in this process of grief work.

4. Guilt - regret for unfinished business. The stages of grief often intertwine and anger and guilt may be simultaneous as the individual goes through a period of "If only's."

5. Loss and loneliness - sadness, depression and self pity. With loss of eye sight or a significant other, the individual may experience a feeling of helplessness. Professionals and friends can help during this period by positive interactions as the individual builds a new independence and meaningful relationships.

6. Recovery - return of hope - a return of the feelings of confidence and enjoyment of life. If loss of a limb, constructive efforts for mobility, if loss of a spouse, an acceptance of the loss and a sense of peace.

Minnie Remembers

Donna Swanson

God,
My hands are old.
I've never said that out loud before
but they are.
I was so proud of them once.
They were soft
like the velvet smoothness of a firm, ripe
peach.
Now the softness is more like wornout sheets
or withered leaves.
When did these slender, graceful hands
become gnarled, shrunken claws?
When God?
They lie here in my lap,
naked reminders of this worn-out
body that has served me too well!

How long has it been since someone touched me
Twenty years?
Twenty years I've been a widow.
Respected.
Smiled at.
But never touched.
Never held so close that loneliness
was blotted out.

I remember how my mother used to hold me.
God.
When I was hurt in spirit or flesh,
she would gather me close,
stroke my silky hair
and caress my back with her warm hands.
O God, I'm so lonely!

I remember the first boy who ever kissed me.
We were both so new at that!
The taste of young lips and popcorn,
the feeling inside of mysteries to come.

I remember Hank and the babies.
How else can I remember them but together?
Out of the fumbling, awkward attempts of new
lovers came the babies.
And as they grew, so did our love.
And, God, Hank didn't seem to mind
if my body thickened and faded a little.
He still loved it. And touched it.
And we didn't mind if we were no longer beautiful.
And the children hugged me a lot.
O God, I'm lonely!

God, why didn't we raise the kids to be silly
and affectionate as well as
dignified and proper?
You see, they do their duty
They drive up in their fine cars;
they come to my room to pay their respects.
They chatter brightly, and reminisce.
But they don't touch me.
They call me "Mom" or "Mother"
or "Grandma."

Never Minnie
My mother called me Minnie
So did my friends.
Hank called me Minnie, too.
But they're gone.
And so is Minnie
Only Grandma is here.
And God! She's lonely!

Film

Minnie Remembers

An older woman is alone, seated in a rocking chair and musing to herself about her past and present life. She looks at her hands and remembers holding a child or walking hand in hand with her young lover, and realizes that no one touches her that way anymore. She muses that no one calls her Minnie anymore - that she has lost most of her primary relationships and that people either call her Mrs. or Mother and she misses being called Minnie by someone that has shared life with her. She does not complain or criticize - just remembers -----

Sample: Reaction to film and discussion
"I felt so sorry for her, she seemed so all alone."
"She ought to get out of the rocking chair and get busy instead of sitting there and feeling sorry for herself."
"I won't let that happen to me."
"Her hands looked so fragile, it made me want to cry."

Points for discussion:
1. The need for introspect
2. The loss of primary relationships
3. The loss of physical beauty and vigor
4. The need for approval for the aging self image
5. The value of long term memories

Film

The Death of a Gandy Dancer

The grandfather in this three generation family faces a terminal illness. The interactions with his daughter - denial, grandson - curiosity are a contrast of coping techniques. His struggle to accept his fate and continue to relate to those around him illustrate many of the steps in grief work.

Discussion of the various portrayals in stages of grief work.
The daughter - refusal to deal with the loss
The grandfather - volatile emotion of anger
The grandson - loss and loneliness
Son-in-law - guilt

Films may be rented from -
Minnie Remembers, Mass Media, 2116 N. Charles Street, Baltimore, Maryland 21218.

The Death of a Gandy Dancer, Learning Corporation of America, 1350 Avenue of the Americas, New York, New York 10019.

Group Discussion

How Can We Be Effective In Helping Others Deal With Grief?

A Shared Experience

Grief is an individual process - each person must experience it themselves - we can not experience it for them. For this session, a retired minister, who lost his wife, his daughter, and his granddaughter in a tragic accident, volunteered to share how he was dealing with his grief. He had experienced his loss a year ago and was in the process of grief work - and realized that it was an on - going process. He said he had experienced two significant stages 1) shock and disbelief 2) the reality of the loss.

Several things had been helpful to him during the last year: 1) communicating with others who had lost family members or friends in the same accident, 2) printed materials that dealt with grief and the emotions that he was experiencing, 3) the response of new found friends, and 4) having one particular confidant to share true feelings with.

Supporting the continuity theory, as a retired minister, he was finding solace in developing a "ministry with the bereaved group." The commonality of the survivors was a beginning for the group, and the needs were similar. The sharing of the various resources which he had discovered, and the benefit of group interaction around a common emotion, grief, was not only helping him deal with his grief, but helping others deal with their grief - and he found pleasure and self fulfillment in helping others.

The Helping Mechanisms

There is no formula or blue print for helping others deal with their own unique grief - but a few techniques and a sensitivity to emotions that the grieving individual may be experiencing might be helpful.

1) Empathy - "Go through the door together," and try to sense how they feel. There is a difference between sympathy, pity and empathy. You may feel a sadness over the loss too, but try to "walk in the grieving persons shoes" and empathize.
2) Patience - Don't try to force the process. The grieving person may appear to be aimless and not wanting to accept the grieving process. Just because you are aware of a few techniques, don't presume you can force the issue, just be there and be supportive.
3) Immediacy - Work with the grieving person's immediate needs - not how you feel about what they say or do.
4) Adjustment - Begin to deal with the fact that the individual now needs to accept an changed environment - a significant person is gone. Explore feelings of how it will be to live without that individual and imagine possible adjustments that might need to be made.
5) Re-investment - Help the grieving individual seek new outlets for formerly shared interests.
6) Self awareness - Help the individual be aware of functioning as an independent person, not dependant upon the lost person or situation.

Current materials found in the news media
1) Ann Landers article
2) Magazine articles
3) Newspaper article about a workshop

Handouts for Participants for Group Discussion

ANN LANDERS SAYS:

THE DYING PERSON'S BILL OF RIGHTS

Dear Ann Landers: I read the letter from "Feeling Guilty" and my heart went out to him. How sad it must be to lose someone you love and then be ridiculed for being the only one who had the decency to tell that person the truth when they asked to know.

I recently took a home health-aide course which taught me, among other things, how to deal with the terminally ill patient. We were given literature that is sure to offer comfort to people in a similar situation. It was put together by the Southwestern Michigan Inservice Education Council and it is called "The Dying Person's Bill of Rights."

Will you please print it? - Been There And Back

Dear B.T.A.B.: Thank you in behalf of the countless people you have helped today. Here it is:

THE DYING PERSON'S BILL OF RIGHTS

I have the right to be treated as a living human being until I die.

I have the right to maintain a sense of hopefulness, however changing its focus may be.

I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this might be.

I have the right to express my feelings and emotions about my approaching death, in my own way.

I have the right to participate in decisions concerning my case.

I have the right to expect continuing medical and nursing attention even though "cure" goals must be changed to "comfort" goals.

I have the right not to die alone.

I have the right to be free from pain.

I have the right to have my questions answered honestly.

I have the right not to be deceived.

I have the right to have help from and for my family in accepting my death.

I have the right to die in peace and dignity.

I have the right to retain my individuality and not be judged for my decisions, which may be contrary to the beliefs of others.

I have the right to discuss and enlarge my religious and/or spirited experiences, regardless of what they may mean to others.

I have the right to expect that the sanctity of the human body will be respected after death.

I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

Outside support helps at first, but then one must call on inner strength, self-determination.

When *she* goes first

By Ron Ferguson

What happens when *she* dies first? What can be done to help the survivor?

People generally tend to focus on the grief and problems of widows. At any given time, however, it is estimated there are 2 million widowers in the United States. Their median age is 71.6, with more than one-fifth under age 60. Most have incomes of less than $3,000 per year. And although there is about a 5-to-1 ratio of widows to widowers, the tragedy is not a numbers game.

Most men do not foresee becoming widowers. One widower recalls, "I had been prepared, as well as anyone ever can be prepared. We'd known for a long time that my wife would not recover, and I guess my first feeling was one of relief that her suffering had ended. Yet there were so many things I hadn't expected at all."

No one really knows precisely how many widowers there are; slightly over half of them remarry. Most of them seem to sink into the larger population. They are known to friends and relatives, but they form no identifiable portion of society, as widows do.

Yet there are several indications that men as a group find the loss of spouses more difficult than do women.

Consider these facts:

- The death rate for widowers is higher than for widows.
- The suicide rate for widowers is high.
- More widowers than widows show increases in physical complaints, doctor visits and illnesses in the first year after a spouse's death.
- Older widowers show a sharper decline in life satisfaction and social interaction than widows do.

One problem is a feeling of "lostness," accompanied by the feeling of loneliness. This "lostness" is especially acute with older widowers.

What can be done to help the widower?

Based on interviews with counselors, psychologists, lawyers and ministers, the following suggestions can be listed.

While husband and wife are both alive:

1. *Develop individual interests.* Couples need to face the fact that someone will die and the relationship will end. If the relationship is a tight, "live-for-each-other" type, the loss will be devastating. Adjustment is better when dependence is not so great.

2. *Be prepared.* Couples should level with each other concerning their feelings about death. Each should know what final arrangements his or her partner desires and where the final resting place should be. One funeral director says usually a daughter, sister, or sister-in-law can best help a widower make plans for the funeral. Just as basic is the need for a carefully drawn will. The survivor also needs to know where all important documents are kept: tax records, Social Security number, insurance policies, will, and other papers involved in estate settlement and benefit claims.

3. *List "who gets what."* Based on some heartbreaking situations, a minister says, "It would save a lot of agony for older men if wives would make a list of 'who gets what' and put it away in a place handy for him. The man is usually at a total loss when claims begin: 'Mother (or Aunt Suzy) always said she wanted me to have Grandmother's china.'"

4. *Consider the wife's attitude.* A widower makes this suggestion: "It's not a transferable thing, but the thing that helped me most was my late wife's attitude. She was very strong, and during her illness she shared that strength with me."

After a wife's death:

1. *Lots of support is needed.* It's a misconception that being male means being tough and self-reliant. A man needs a lot of support at the loss of a wife—support from family and close friends. He should be made to feel that he has not been forgotten and that he is not an outcast.

2. *Avoid the "empty-house syndrome."* For most widowers it is an awful experience to come home to an empty house. One widower helps remedy this by making the bed in the morning before going to work and by buying an electric timer that automatically turns on the lights in the house before he gets home in the evening.

3. *Develop a new and active life, with or without remarriage.* Work is very therapeutic. And the widower should force himself, if need be, to get out and socialize.

4. *Seek help if necessary.* Before plunging into life-destroying despair, a widower should seek professional help from a minister, counselor or community referral service.

By far the greatest resource a widower has in the readjustment process is himself.

One recently bereaved husband describes his adjustment thus:

"When two people marry they are usually quite young and flexible. Years later when the wife dies the man may be more set in his ways. It is much more difficult to batch it—possibly for the rest of his life—and it may be even harder to find a suitable mate.

"For about the first year I just stayed home. I sort of cleaned up all the loose ends, paid all the bills, things like that. It almost seemed like I was working for a clean break, maybe closing a door.

"After my wife's long illness and the final service, I had the strong feeling, 'Just leave me alone.'

"I felt, 'Okay, everybody, you've been great—helped me—but now I've got to do this by myself. I've got to keep things afloat in my own way.' I think I made some nice people mad."

There is hope. This man changed. He made it. And so can any widower if he looks within himself for the strength his maturity gives him.

If a widower keeps a positive attitude and looks to the future, unexpected surprises may await. As one widower says, "After about four years, I'd just about decided I should spend my life as a bachelor. Then—I met the woman I was later to marry.

"Life began all over!"

Abandonment wrong —

Terminally ill need comfort

By LESLIE CHAMPLIN
Health Writer

One of the failures of health and counseling professions is abandoning the terminally ill or injured after they have received the bad news, according to Dr. John Homlish.

The person who tells a terminally ill patient that he is dying "also has at that point the responsibility not to abandon that person," Homlish said.

Homlish, a member of the Interdisciplinary Studies Program at the Menninger Foundation, told approximately 20 persons attending a two-day "Death and Dying" seminar here that the dying person requires comfort and companionship, despite the fact that his death is an experience shared by no one else.

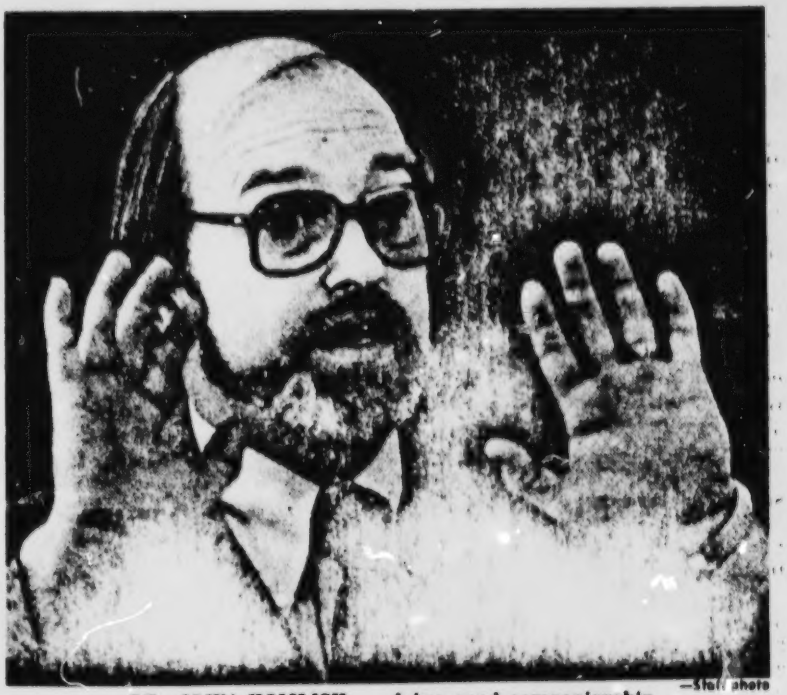
"One of the failures is that we find that the bearer of bad news doesn't stick around," Homlish said. "In times of crucial turning points in our lives, what we look for are friends and companions. The minute you tell the person (he is dying) — then to walk away and say, 'I only told you the truth,' is immoral.."

Too often, people shun death or treat it as a passage to a different form, Homlish said.

"Too often we look at dying as a painful, if necessary, bon voyage party. But we are not talking about a fairyboat ride to the other side," he added. "When you die, you don't get better."

That fact, among others, mandates that a dying person receive support, companionship and comfort, he said.

"To say, 'Your world is ending,' then to say, 'I will not be a companion,' strikes me as one of the clearest examples of immorality. More and more people are prepared to become involved, so that we may assist (the dying person). It's a moral thing to do."



—Staff photo

DR. JOHN HOMLISH ... dying need companionship

The physician and nurse, while working with the dying patient, become companions in "an ultimate event," Homlish said. That companionship and support is requisite, despite the fact that dying is a very personal, individual event with which no outsider can totally empathize.

"I know I have to die alone, even if the room is full," he said. "Finally and decisively, I am an individual at that point. It is, from my point of view, literally the end of the world."

Offering moral support to the terminally ill or injured is not the only moral question. Whether to artificially prolong life and whether to allow a person to die when he requests it are questions the medical and other professions must answer.

Citing as an example a severely burned pilot who survived a crash but pleaded with his rescuers to kill him to ease the pain, Homlish asked, "Does the person have the right to take his own life in that case? And if he cannot, does another person have the right to do it for him?"

On the other side of the question, Homlish asked whether physicians have the right to artificially prolong life.

"We have to ask whether the quality of a particular life has been so destroyed that we have the right to prolong it, except to test out the machinery, the equipment. In that case, the person becomes the means," he said.

"The question we have to ask ourselves is why are we keeping the person alive. Out of respect for the person, respect for his life?

"It does no good to have five people put their hands on the plug and pull it, so no one is responsible," he continued. Such a method of deciding such issues fails to answer the ethical questions.

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SOCIAL GERONTOLOGY

UNIT #2
GERONTOLOGICAL MENTAL HEALTH (CS 312)

SESSION #6
DEATH AND AGING (CS 312-B)

Resource leaders: Helen Miller, Co-ordinator, Osage County Council on Aging, Osage City, Kansas
Elizabeth Wooster, President, Hospice, Inc. Topeka, Kansas
Sylvia Nelson and Florence Litton, board members Hospice, Inc.
Doris Hammond, Nurse, Memorial Hospital, Topeka Kansas
Jeanne C. Tucker, Director, Gerontology Institute Washburn University

Suggested Agenda

Introductory lecture: Death in America: No Longer a Hidden Subject

Lecture and discussion: Suicide rates among the elderly

Group discussion: Ten questions and answers about death in old age as seen by Dr. Kubler-Ross

Panel presentation: The Hospice concept in Topeka

Presentation: Personal interactions with dying individuals

Feedback and evaluation

Objectives of Session #6

1. Develop an awareness of the impact of advanced age on the older person's perspectives regarding his personal past and future.
2. Discuss the fundamental unity and continuity of the human life cycle from birth to death.
3. Develop an awareness of the particirant's own aging process and its implication concerning his own death.
4. Discuss institutional practices concerning death in American society.
5. Discuss the Hospice concept and the benefit of individualized caring for terminally ill patients.
6. Present individual concepts and attitudes of interacting with a dying person.
7. Discuss the rising suicide rates among the elderly.

Introductory Lecture

Death in America: No Longer a Hidden Subject

A new consciousness is spreading fast among young and old alike that dying, like other stages of life, must be faced openly and honestly. Americans by the millions are taking a new and unflinching look at the reality of death and how to cope with it. Bookstores are flooded with best - selling books, television and movies dramatize this new consciousness and college classes are heavily attended by individuals interested in the topic. Perhaps, nurturing the death awareness movement is a growing belief that the individual is losing what many consider a basic right: the power to control one's own dying process.

Scholars see a variety of reasons for Americans' rising consciousness of death at a time, ironically, when humans have conquered most infectious diseases, and longevity in the U.S. is at an all time high. Some note that in today's wide open society, death may be the last taboo to be exposed and examined. Others point to the estimated 1.9 million deaths in the U.S. this year, 80 percent of which will occur among persons above the age of sixty five.

Researchers in the growing field of thanatology -- from thanatos, Greek word for death -- speculate that the generation that reached maturity during and after the Cold War looks on death with more abstraction. "Young people who grew up with the threat of 'The Bomb" wreaking megadeaths across the globe, and who saw life cheapened in the Vietnam experience may be able to view death with more equanimity than previous generations," says Robert Fulton, sociology professor at the University of Minnesota. "There may be a subconscious sense of futility about the future in their minds."

The modern pioneer in the movement to bring death out of the nation's closet is Dr. Elizabeth Kubler-Ross, whose book describes the stages of the dying process and examine the special psychological needs of dying persons. Some of her observations include that Americans refuse to admit that they might die; that we are a death - denying culture. Fewer than 25 percent have wills, and many consider death an embarrassment that should not be discussed openly. This country is a leader in the heroic medical efforts to preserve life and commonly isolates terminal patients in institutions and away from active, well individuals.

Today, the "good death," a public ritual in which a dying person is comforted by family and friends, is seldom experienced. In America, some 70 percent of those who die spend part of their final year in a hospital or nursing home, dying slowly of chronic health problems. Current, "aggressive medical care" doesn't allow death to occur quickly and naturally.

At more than 1,000 educational institutions, from elementary grades to medical schools, the subject of death is being discussed openly in formal classes. Most of the discussions focus on living rather than dying and that is perhaps a positive element of thanatology. This kind of thinking can stimulate us to develop priorities and to communicate our esteem, respect and love to those dear to us before they die. One major concern of educators is that death might be romanticized and euthanasia and abortions viewed in an unrealistic perspective.

A remark of the dying, frequently heard by physicians and counselors is "I am not so much afraid of death as I am of dying." Surveys show that Americans in particularly fear a painful, lonely, dehilitating illness. As we think about aging and our life cycle experiences, we might keep in mind that this is a very real perspective for an older person. Fear of dependency, dread of pain and resistance to the loss of human dignity may be more feared and rejected than the final life experience -- death.

Reports show suicide rate soaring among elderly

N.Y. Times News Service

NEW YORK — One Los Angeles doctor who specializes in the treatment of the elderly finds that, from time to time, he has to prescribe sleeping pills. When he does, he always makes this little speech:

"Now, I'm giving you this medicine to help you sleep," he says, "and I'm giving it to you as an act of good faith. Do not respond with an act of bad faith. Do not use these pills to kill yourself without talking to me first."

That doctor is not worried about placing suicidal thoughts in the minds of his patients. He is more concerned about the need to confront openly the thoughts of death that may already be there. Suicide — so widely discussed when it occurs among the young or among the middle-aged — is predominantly, albeit quietly, a phenomenon of the aged.

Every year, 5,000 to 8,000 Americans over the age of 65 kill themselves. They account for 25 percent of the total number of reported suicides, although the elderly make up only one-tenth of the population. And the number of elderly suicides is, in the opinion of specialists, much higher than the reported figure because the aged can kill themselves in ways that are not easily detectable, such as intentionally neglecting to take life-sustaining medicine.

The high rate of reported suicides among the aged has existed for years. But it was rarely noticed, written about or researched. Now, as the field of gerontology expands rapidly, awareness of the problem is intensifying. A picture is beginning to emerge of who the elderly suicide is, what his motivations are and what measures can be taken to prevent suicides.

The depression that leads to suicide, as gerontologists describe it, is in many cases brought on by an irreversible progression of losses. One's work is gone, and so are friends. A spouse has died. The children have moved away. Even the past is lost as memory fails. Painful illness has replaced physical well being. Self disdain has replaced self esteem. Hope has disappeared. There is a sense of passivity and helplessness. The holiday season, as with depression at all age levels, can exacerbate the feelings of loss and isolation.

The individual least likely to cope successfully with the losses of old age appears to be the white male. In the 70- to-74 age group, for instance, white men commit suicide at a rate nearly three times as high as that of nonwhite men and nearly five times as high as that of all women the same age.

Why? The speculation is that young white men in this society are able to achieve more than members of other groups and so the deprivations of old age strike them harder.

Dr. Adrian Ostfeld, professor of public health at the Yale University School of Medicine, suggests that "a man who has his sense of self confused with his work may come to think of himself as nothing when the work is gone."

As women increasingly engage in traditionally masculine behavior, it is Ostfeld's expectation that they too will be more vulnerable to suicide.

A dramatic difference in suicide attempts made by older people and those made by younger people is in how often the attempts end in death. Among adolescents, there are seven attempts for every actual suicide. Among the elderly, the ratio is two to one. This leads specialists to the conclusion that the elderly are not crying out for help, as is so frequently the case among the young, but rather they are simply trying to end lives that no longer seem endurable.

The elderly often die quietly, without so much as a suicide note to explain their despair. And that contributes to the difficulty in arriving at accurate data. Discussing the underreporting of suicides among the elderly, Dr. Allen Willner, a psychologist who directs the Senior Citizens Treatment Program at Long Island Jewish-Hillside Medical Center, makes a conservative guess: For every reported suicide there is one that is not reported.

The underreporting is a special concern of Dr. Norman Farberow, co-director of the Los Angeles Suicide Prevention Center. He and his colleagues have been studying the behavior of nursing home residents and have noted a great many ways to commit suicide that are not readily apparent. When the elderly fail to take their medication or take too much of it, when they have accidents, when their appetites disappear, all of these behaviors can be intentional

Moreover, because the death of an old person is generally thought of as an expected event, a suicide that would be obvious in a younger person may go unnoticed with an elderly victim. Dr. Eugene Seymour, a physician treating the elderly, recalls looking into the case of an elderly man whose death was described by the coroner as the result of natural causes. However, Seymour said his questioning of the landlord revealed "that there had been a smell of gas in the apartment at the time of the man's death — and all the windows had been taped closed."

Detection of the depressive symptoms that might lead to suicide in the elderly is more difficult than it is in younger people. Depression among the elderly, as one psychiatrist put it, "is less florid," and thus less obvious. Certainly, though, there are signals. If an older person has stopped all activity or is losing weight at about 2 to 4 pounds a week, these are causes for alarm. If an older person jokes about taking his own life, the joke frequently conceals serious intent.

The treatment of the depression associated with suicide is complicated in the elderly because common antidepressants can have side effects that work against their usefulness. They might make a patient sleepy at a time when it is the very lack of alertness that is a contributing factor in the depression. They may affect heart rhythms at a time when the heart is growing more fragile. At the moment, there is experimental work with drugs that produce fewer side effects, but the drugs are not yet available in this country.

Psychotherapeutic approaches center on alleviating some of the causes of depression. At Long Island Jewish, for instance, Willner, Marsha Leader and other therapists will attempt to help an aging person compensate for the loss of some mental ability. If he can't remember well, they teach him to make lists. If all the chores he must do seem overwhelming and he can't tolerate the stress, they teach him to focus on priorities.

At the Los Angeles suicide center, the therapists will try to reduce the isolation that results in the loss of a sense of self worth. They'll help a patient get involved with people again, preferably with members of his family.

Group Discussion

Ten Questions and Answers About Death in Old Age as Seen by Dr. Kubler-Ross

Many people believe that death is a welcome friend to most elderly people. This is only partially true. Old age is not synonymous with being "glad to die." Many of these old patients who welcome death may not be in a stage of acceptance, but rather one of resignation, when life is no longer meaningful.

Our old age homes are a sad reflection of our lack of appreciation of our elders. We give them shelter, room and board, at times even color television and swimming pools, golf courses, and dancing facilities, but we deprive them of the chance to still serve, give and offer their unique services - namely, all the wisdom and experiences they have accumulated over many decades. Living means to give and to take, to receive and to serve others - and it is the latter that is often missing in our retirement centers, which results in the old man's (or woman's) wish to die, because life is not worth living anymore.

1) Old Age
Many older people say they want to die. I don't blame them, but can you really say that you would feel the same way?

Naturally you can say that. Patients respond to you in a much more open fashion if you are honest with them. If you feel that their quality of life is really not worthwhile anymore and they express it verbally, naturally you can agree with them, but you have to add at the same time, "Is there anything I can do for you that makes life a little bit more bearable and a little bit more meaningful?" They will come up with some marvelous ideas sometimes, things that are not time consuming but require an open, honest question and a caring human being to respond.

2) Do you think some of your teaching films should be shown to patients in geriatric centers?

All of the films we made on death and dying can be shown in geriatric centers as long as the patients are told what the film is all about and that they can choose to attend or stay in their rooms.

3) How do I help a member of my family in a nursing home reach acceptance instead of resignation? How do family members help?

The best way would be to take them home to live. It is much easier to accept one's finiteness in a familiar environment than in a nursing home where he is visited maybe once a week or once every two weeks. If this is not physically possible you should talk with the older person and explain why it is not possible for him to go home. Ask simply and straightforwardly, "What can I do to make your life truly meaningful in spite of the fact that you are in a nursing home?"

4) How does one deal with one's fears of the death of parents who are getting older although they are not ill or in immediate danger of dying? Does it indicate a fear of being alone?

I think it indicates that you are afraid to lose your parents. Sit with them, talk with them about it, make arrangements now before it happens, and discuss with each other what has had meaning in your life and what will make such a separation more bearable. You should do this before illness comes or before your parents have a stroke and may not be able to talk about it.

5) I have just started working with senior citizens and it seems as if they go through the stages even though they may not have a diagnosed illness. Is that a correct observation?

This is very true, especially if they have been moved to a nursing home. They are going through the same stages that anybody will go through, not only if they face death, but if they have to come to grips with and loss. An old person who has lived at home for a long time and then is transferred to a nursing home will have to go through the same adjustments because of the loss of a home or of a family, or simply of a functioning existence.

6) Do you find elderly persons who face nursing homes after hospitalization willing to talk about death? I found often that they talk about "death of an active home life."

This is very true. There are many forms of death. If a patient is hospitalized and hopes to return to her home environment and instead is transferred to a nursing home, she very often talks about this and implies that "this will be my death." This is sometimes referred to as "social death."

7) How do you help nursing home residents cope with what they miss - all that home symbolizes?

You try to make the nursing home as much a home as humanly possible and that means that you include children, not only for visiting, but for residing there at least during the day (in day-care centers) so that the old people can help with the little ones. The elderly can perhaps plant a little garden and do some woodwork and all the other things that used to make life meaningful at home.

8) How would you answer an eighty-six-year-old grandmother when she states, "I wish I would die" or "I want to jump off the bridge." She is in restraints in a nursing home.

If I were in restraints in a nursing home at age eight-six, I would also jump off a bridge if I had the energy to do so. Has anybody ever tried taking her off the restraints, putting her in a wheel chair, and taking her for a walk in the garden? These little services to old people can make their lives, if not pleasant, then at least a bit more bearable.

9) How does one help an aged parent accept the death of a middle-aged child?

Any parent who loses a child goes through a tremendous loss and it will take years, sometimes, to come to grips with the loss of a child. It does not matter if the child is five years old or fifty years old. For the parent, he will always remain a child. You continue to visit those parents, you let them talk about it, you let them show you pictures of the deceased child, and find out how best you can help them. Needs differ from parent to parent.

10) How would you hear or interpret the statement: "When I get too old to live, I'll go out in the woods and take a shotgun with me"?

I don't think this requires much interpretation. What this person is saying is that he does not want to get too old so that he is a burden and end up in a nursing home, usually rejected by the family, in a meaningless existence. These people want to be able to "call their last shots."

Excerpts from Kubler-Ross, Elizabeth, Title, Questions and Answers on Death and Dying, Publisher, MacMillan Publishing Co., Inc., 1974.

Panel Presentation

The Hospice Concept in Topeka

HOSPICE, originally a medieval term for a way station where travelers could rest, today describes a place of meeting and giving of special care for the terminally ill. The first Hospice, St. Christopher's, was established in England in 1967 and has become a much visited model.

In 1974, Hospice, Inc., New Haven, Connecticut, was the first hospice founded in the United States. Today there are an increasing number of hospices being formed to meet the needs of the terminally ill. The hospice concept was needed to provide home care and individualized care for dying patients. Active involvement of families and friends in the care and concerns of the patients was a vital ingredient. Several variations have evolved to meet the unique needs of communities and terminally ill individuals.

St. Luke's in New York City has rooms scattered throughout the hospital, rather than a concentration in the "terminal wing." Other models are referred to a "hospice without walls" and carry the concept to the homes of the patients. The attention of medical teams and families create supportive climates for the dying individual.

The growth of the hospice movement has been rapid. Medical science has long concentrated its efforts on curing--and has devoted little attention to the care and comfort of the dying. Prolonging life has been the ever present objective, even in terminal cases.

Patients in the hospice are not attached to machines or given drugs for the purpose of prolonging life. Medication and machines are used to lessen pain and make the individual as comfortable as possible. Families visit at all hours and often. They are encouraged to prepare favorite foods, bring pets to visit, and make the surroundings as home-like as possible. Family members receive counseling and support as do the team members of the professional staff. Staff members are available on a 24 hour basis to care for the patient or give support to the family. A major objective is to keep the patient in a home setting for as long as possible and to develop a high degree of individualization in the care and interaction with the patient.

The philosophy undergirding the hospice movement is that quality of life is more important than added years, and that everyone has the right to die with the support of other humans and with as much dignity and respect for self as possible.

Topeka has joined this growing movement--has an incorporated group known as Hospice, Inc., Topeka, Kansas. In August, 1977, a group of Stormont registered nurses and members of the Altrusa Club of Topeka, Kansas, began exploring the Hospice concept of patient care for the terminally ill. In February of 1978, the steering committee invited a few individuals in the community to an informational meeting. Twelve made reservations and nineteen came. From that time forward, meetings have been held once a month. On March 22, the Junior League of Topeka, Inc.

became an advocate of the program. Bylaws were adopted, a board of directors was elected, and the group become incorporated on September 27, 1978, just one year, one month and ten days after the idea was born. Presently, they staff an office with volunteers in donated space in the Central Congregational Church.

Topeka hospice care is composed of the following ingredients:

1. Quality of life is more important than the quantity of life.

2. Medical and nursing care are directed toward comfort not cure. Control of pain and other symptoms is a major function of hospice care.

3. Hospice personnel are available 24 hours a day.

4. Volunteers, professionals and non-professionals are an integral part of the hospice team.

At this point, funding has come from the three organizations--Altrusa Club of Topeka, Junior League of Topeka, Inc. and Hospice, Inc.--as well as contributions from other organizations and individuals. Hospice, Inc., Topeka, Kansas, having filed for non-profit and tax exempt status, is seeking donations from foundations, local businesses, community groups and individuals.

GOALS

1. Patient Care. To develop an umbrella-type of comprehensive outreach program for the terminally ill and their families; using the existing outreach programs and expanding the scope of ones in the planning stage.

2. Education. To teach the community, families and patients about the needs of the patients with a terminal illness. To teach the community how the needs of the patient with a terminal illness can be met.

3. Research. To develop a program that will provide an evaluation of the program as to quality of care and cost effectiveness.

4. ULTIMATE GOAL. Hospice With Walls. Staffed with professionals.

Hospice may not be the only answer and fit everyone's needs. Some people may have a strong desire to fight for life and continue every means possible to achieve a cure. Life support systems, surgery, medications and various treatments are certainly acceptable means of coping with a terminal diagnosis. Individuals involved in the hospice concept are encouraged to take whatever medication the physician recommends for comfort, and utilize whatever else medical science can offer for their comfort--but that is one of the primary concerns--the patient's individual desires and personal comfort.

The Hospice: a Bridge From Life to Death

When her mother's cancer was pronounced incurable, Rosemarie Fink braced herself for the inevitable prospect of watching helplessly as death approached.

"I'd never worked with ill people, and didn't think I'd be able to keep Mother at home and care for her properly," says the Montville, N.J., woman. Then she was referred to the Riverside Hospice, an organization that had been formed to care for the dying. "The hospice people helped with everything - running errands, assisting with insurance and medication, giving all kinds of useful advice on how to make Mother's last months as effortless as possible," says Fink.

Such experiences underline the big change in care of the dying that is occurring as more Americans turn to hospices to help them best live their final days. The concept began in England as an alternative to hospital care for the terminally ill. Hospices attempt to provide three things: companionship, relief from pain and adequate medical and psychological care.

While most hospices have some inpatient - care facility, they urge families to care for a dying person at home if possible. "When the family is intimately involved with a dying member, there is much less guilt afterwards," says Susan Silver, an official with the National Hospice Organization in Washington. "They witness the natural dying process, they give of themselves, and their grief is not so prolonged."

The National Cancer Institute, medicare and Blue Cross and Blue Shield have all expressed interest in hospice care, both because of its humaneness and its cost. The American Hospital Association places the average cost of a day's hospital care at $151.79. By contrast a recent study by Hospice, Inc., in New Haven, Conn., put the cost of its home care for dying patients at about $750 over a period of three months.

Once a patient is diagnosed as incurable, hospices do not believe in prolonging suffering through high - technology medical procedures. Every effort is made to make a patient's last months as joyful as possible: Rules are avoided, visiting hours are round-the-clock, and pets and personal effects are encouraged.

Some observers worry that hospices could spring up so fast that standards slip. Others urge precautions to keep hospices from being seen as "death houses."

"The hospice concept clearly has come of age," says Dr. Robert N. Butler, director of the National Institute on Aging. "But we shouldn't overcommercialize the idea .... That could destroy a great opportunity to help persons who are facing catastrophic illness."

Reprint from U.S. News and World Report, November 13, 1978

Presentation

Personal Interaction With Dying Individuals

This past week, many people have asked me what I would be talking about at Washburn University. Seventy-five percent of these people blanched, sputtered, or said, "How gross," Masochist! etc. This speaks to me of the pertinent necessity of knowing, coping and understanding Death and Dying.

The Lord had prepared me for troublesome times. From September '76 to September '77, I lost eleven members of my family. Ten of them were terminal, one was in an accident.

I wish to relate directly to you about patients who knew they would die within hours or days.

Many years ago while working with a client from the law office where I was employed, I experienced my first meeting with death. After this excruciating encounter with the "grim reaper" I felt compelled to explore the possibilities of a better way of sharing with a person and their last hours. Quite by chance I saw Elizabeth Kubler-Ross on T.V. It was noted that she would be a guest speaker at a local college. She opened a whole new world to me. From there my new adventure began. To me death is the second most important part of living. Birth then death. She explained to us, as has been indicated early on in this course the five (5) steps or stages one travels through upon notification that they were going to die.

They are as follows:

1) Denial
2) Anger
3) Bargaining
4) Depression
5) Acceptance

Some of her newer theory indicates, that some people may not enter all these stages, and then some do.

In our society, we are geared to life, living, youth, good health, etc. Those most particularly involved with this business of dying, besides the patient himself, are the doctor, and the nurse. Unfortunately, as a rule, they find it harder to accept as the medical profession is dedicated to healing. They find it foreign to their programmed way of life to deal with losing a patient. It is a threat to their credibility. This coupled with the patient and the family's tremendous fear of death, the process of dying becomes a horror, rather than an experience of love, sharing and support of one another.

Our statistics show that in most skilled facilities, 92% of all patients die alone. In a recent survey conducted in California they lay claim to 90% in an acute facility. If we had our druthers, each and everyone of us would prefer a quick, painless death. Unfortunately, three fourths of the time this is not the case.

We are all afraid to die, at one time or another in our lives, some of us always. Contrary to what many authorities say, I have found from personal experience that many of those that I have worked with want to die. They feel they have outlived their usefulness, self worth is low. They have gone beyond their physical and emotional resources. Their reserve is low. They welcome death.

All of us are entitled to comfort, respectibility and dignity when we die. We need love, expressions of concern and support in our last days. Generally we want to talk

about it if given the opportunity.

Perhaps my experiences can be shared as life experiences which would hopefully raise the consciousness level and sensitivity of others in their realistic approach to death. My experiences with death have always been on a personal level. Of the six or more cases that I have shared these last days with, only one has rejected my overtures. The rest eagerly reached out to my inquiries. They had gone beyond in their minds the possibility of death, they were now facing reality.

1) God-father Bumstead. He wanted to die. He felt he was no longer useful and had nothing to contribute. He was confined to a wheelchair. His wife confined to bed and he hadn't been able to understand what she has said for five years due to a stroke. He had been a most active man all his life; owned a sporting goods store, and hunted, fished and all those good things. He just couldn't seem to accept his dependent situation. He willed himself to death.
2) Mrs. Evelyn, I had cared for her business and watched out for she and husband for over two years. The Dr. called and said she had broken her hip. He was putting her in the hospital to die, because she had pneumonia and he didn't think she would last long. I sat with her three hours. Not once did a nurse or doctor put their head in the door to check, as she drifted back and forth from consciousness. I would hold her hand, wipe her brow and tell her how much I loved her. Everytime I said that, she opened her eyes and smiled. She died at the end of the three hours, and I went out to the staff to let them know.
3) Daddy. He had cancer of the bone which is terribly painful. One day we sat talking to an uncle who had lost his wife the previous year. As a widower, he had grieved more than most, and we were trying to console him. I said to him, "Well you know Aunt Lois is only a heart beat away." My father who hated to show his deep emotions to anyone grabbed my hand and held it so tight, and said "Oh Honey, I am so glad you feel that way." From then on till he died, we could talk about his approaching death, the pain, the loss he would suffer.
4) My Uncle Everett was another that I was with at least once a week for over a year till he died. He rejected any overtures that I made to him, and turned out to be the most fearful person I have ever encountered. I felt it could have been so much different if he had accepted the fact that he was dying, but this was <u>his</u> choice, and who was I to say.
5) My Mom, terminally ill with cancer seven years, she was facing more surgery for cancer. The Doctor called and said I had best come home, she was quite ill. He never once ever said to me, "She is going to die," or that she might die. My mother had spent years at City of Hope. Prolonging her life through experiments was their main goal. To me, it became an enigma; operate, fix her up till the next time. When the Dr. let me know the condition she was in, along with pneumonia, I asked him to enter her into the local hospital until I got there. When I arrived all the family agreeded that at age 87 she had suffered enough. There would be no more experiments. Mother had reached point where she was totally worn out. She had no reserve and she was looking forward to death, as a relief. Three weeks before she had suffered a tragic lost her only granddaughter in an accident. She knew I was coming and literally held off till we got there. Our family was with

her 20 hours a day, her brothers and sisters, children and grandchildren, along with a special nurse. Our way of doing for her was totally foreign to what the hospitals and doctors methods were, but they encouraged us. We all helped the special nurses, wiping her face, spooning ice cubes, re-affirming our love and concern for her and holding her hand. She was a very strong Christian, and was not the least bit afraid. She prayed with me a lot, and talked about the excitement of going and seeing her Lord and her loved ones. She talked with each one of us separately, expressing love and saying good-bye. She went off to sleep and several hours later she woke up. I was sitting with her, holding her hand. Amazement shown in her face when she realized she was still alive. We discussed why it was taking so long. She said, "I am so ready to go. How do I do it? Is it so hard to die?" I suggested to her that she just try to relax and to pray, "God will be with you all the way;" We prayed together many times those next two days. One of the LPN's came in and prayed with us a couple of times. I had gone home to my son's to try and get a few hours sleep and was in bed about 30 minutes when I knew I had to go back to the hospital. So in the dark of the morning, I drove alone back to see her. When I walked in the room she said, "Oh Helen, I love you in red, you look so pretty in red." A few seconds later, holding my hand, she looked at me and said "Sweetheart, I love you," and was gone. She had never called my brother or I endearing names. I know she saw her Ray, and he had come to help her through to the other side.

As the Special had left the room, to get the head nurse, I was alone. I took her in my arms and held her close and loved her, hoping it would make her journey easier, and too, to be able to hold her one more time.

The Special came back with the head nurse and found she was gone. The head nurse asked that I leave the room immediately. I, of course, wanted to know why, and she said she had to use rescue methods on my mother and I couldn't be present. I took her by the arm out into the hall and made it very clear that I didn't want her touched. "Don't bring her back, she wanted to go, there is nothing but grief and pain to come back to. Leave her alone and let her have respectability and dignity."

I feel that I had blessings bestowed on me prior to losing my mother in that I could have such a meaningful relationship with her when she passed away. I know it helped my family, and particularly my children. It is a lot different to read about death, hear lectures, see T.V. programs, than to actually experience it. I felt I had experienced tremendous growth on my part with each case. I just wish I could have been more effective or helpful in earlier encounters with death.

It takes courage to be bold. Next time I would hope I could draw the doctor and nursing staff into it more deeply.

The experiences I have shared with these people have been invaluable to me... All but one had a sense of that which was beyond ..., That they had a future after death. All accepted my love and prayers. It is my hope that eventually there will be enough education and experiments that all of us may face death with comfort and anticipation. I, for one, hope to delve deeper and deeper into this exciting new area.

Presented by Helen R. Miller, Co-ordinator, Osage County Council on Aging, 2nd & Market, Osage City, Kansas 66523.

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SOCIAL GERONTOLOGY

UNIT #2
GERONTOLOGICAL MENTAL HEALTH (CS 312)

SESSION #7
AGING AND LEISURE (CS 312-C)

Resource leaders: Don Vest, Ph.D., Counselor, Washburn University
Vivian C. Umbarger, Higher Education Act Title I project coordinator of Social Gerontology Workshops
Jeanne C. Tucker, Director, Gerontology Institute, Washburn University

Suggested Agenda

Introductory lecture:	How do we "weather the years?"
Lecture:	Is leisure boring?
Video presentation:	More than a gold watch
Group exercise and discussion:	The creative aging leisure puzzle
Feedback and evaluation	

Objectives of Session #7

1. Discuss the need to be aware of our own construct of leisure/work.
2. Develop an awareness of the prestige/stigma that is attached to leisure.
3. Discuss the differences of leisure during career years and after retirement.
4. Discuss the role of boredom in an older person's mental health.
5. Present materials that suggest creative ways to find alternative leisure.
6. Involve the participants in individual leisure activities to stimulate further research into personally fulfilling leisure stimulus.

Introductory Lecture

How Do We Weather the Years?

Leisure - what is it to you - or to me - how important is leisure time to our life styles? What would you be doing right this minute, if time or money was no object - what dream do you carry of an ideal leisure moment? I see myself on a white sandy beach walking along the surf picking up sea shells. The sun is warm and the foamy surf laps over my bare feet - but - lets really use our imagination. Project your thoughts to your retirement years and visualize what type of leisure activity you would find desirable. Is it the same or different? I still find myself on that white, sandy beach - but now, I'm living in a little beach cottage and not just there on vacation.

But, perhaps finances or health might keep me off that beach. It might be a good idea for me to have some alternatives available. H. Dan Corbin, chairman of Recreation Studies at Purdue University says

> "The advisability of acquiring diversified interests at an early age cannot be overstated. Certainly leisure awareness should be brought into sharper focus during the middle years to prepare for satisfying retirement years. By doing so, there will be a less drastic alteration of the self image and continuation of self fulfillment, recognition creativity, self worth, dignity and holistic satisfaction. If an individual waits until retirement to consider alternatives to the past routines, the task may become overwhelming."

Our fears about aging are reflected in the jokes we tell. "We've no longer in the rock and roll generation - but rock and wobble," "Don't worry that you're over the hill now." It's good to be able to laugh about the stresses of aging, but we don't want to scorn or deny that adaptations may need to be made and we may need some strategies ready to cope with the stressors. Losses of youthful beauty and vigor, decline of physical energy and reduction of meaningful roles may create life crisis as we complete developmental tasks in the life cycles.

As long as you are alive, you will face developmental tasks and changes that will stress your body, your emotions and your mind. Can one learn to "age gracefully" and be content and happy to grow old? Perhaps the social theory of aging called the activity theory will help you age successfully. The activity theory says that the person who ages successfully stays active. New activities are found to replace those that are no longer appropriate - or physically impossible. But, caution needs to be exercised not to just be busy for busy's sake. One statement made by older adults is that they have less energy than before. "When I was young, there was nothing I felt I couldn't do." One of the important strategies of growing older is to conserve energy - save yourself for the big things and activities that bring self satisfaction.

Attitude plays an important role in how we weather the years too. If you expect to be able to cope with the stress of aging, you are a long way toward being able to.

Hope - optimism may help you mobilize your energies and increase your effectiveness in reacting to stress. Realizing that there may be some cloudy and rainy days ahead as you age can help you "age gracefully" and actively looking for the sunshine can "Help you stay young hearted." How we spend our leisure years is really up to us - beachcombing or riding the surf - it's how we decide to "take our leisure."

Leisure

Is Leisure Boring?

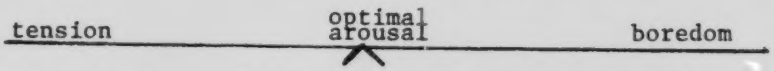
We spend our waking hours everyday doing something - tasks related to survival and leisure time. As we grow older and retire from work roles, we find we have a larger percentage of our time filled with leisure time. Are we prepared not to be bored?

Generally, we define boredom as having no sense of accomplishment, experiencing no challenge or arousal, sensing a lack of meaning or a degree of indifference toward life. Activity directors working with older individuals are sometimes guilty of pointing to attendance and the number of handmade ashtrays as indicators of meaningful adult programs and leisure time activities. Bingo, card games and crafts may prove self-fulfilling to some, but other old people may need a different sort of programming to derive enjoyment and a sense of self worth.

We should be aware of the types of activities that bring us a sense of well being and enjoyment and plan ahead to utilize our leisure time in retirement. And, we should be sensative that others may not experience the same level of arousal from an activity that satisfies our needs.

Researchers are studying several theories of aging. Disengagement, or a gradual withdrawal both by society and the individual as energy levels decline and roles diminish. And, the continuity theory or continuing to engage in activities that have been satisfying. If an individual has always received a lift and a sense of satisfaction from classical music, they will likely enjoy a program of that type in retirement. But, if setting and listening to this type of music is just so many violins squeaking and makes the individual feel tense and anxious - that is the wrong level of arousal. Or, if one finds the music repetitious and dull, they might experience another level of arousal - boredom. Being involved in self satisfying activities is important during every life cycle - no less so in the later years.

We all seem to have an optimal level of arousal which will produce self satisfaction and balance tension and boredom.



This arousal is the individual's reaction to stimulation from outside and inside the body. It is the conversion of potential energy into some sort of action - an intensity or a sense of being alive. The level of arousal can vary from very little, as in a coma, to a great deal involving extreme energy, such a winning the decathlon championship in the senior Olympics.

There seem to be three types of arousal that impinge upon us: 1) behavioral arousal 2) emotional arousal and 3) mental arousal. In some activities, all three arousals occur, but it is possible to escape boredom or tension with just one type of arousal. as we age and our physical energy declines, we may achieve optimal arousal by substituting mental arousal for behavioral arousal. Behavioral arousal involves stimulation coming from the muscles and expending physical energy. Perhaps, as one ages, mentally watching the touchdown can be as fulfilling as actually running the ball over the goal line.

But, as we age, we need to avoid "the only game in town" syndrome. As physical energies decrease some older individual find they become boredom susceptible. Boredom susceptibility occurs when experiences seem to be repetitious and our cohorts seem to be dull and predictable. Socially unacceptable behavior may be the defense mechanism used by the retiree to fight the boredom - saying outrageous things, wearing inappropriate clothing, drinking too much - may all be ways of fighting the boredom and striving for an optimal level

A more satisfying behavior to combat boredom is to seek new experiences. New adventures through the mind and senses can stimulate as novelty, surprise and complexity intrigue the mind and create a sense of self worth. Travel, trying your hand at the potter's wheel, going back to college to take astronomy, volunteering in a community service are all possible life enriching experiences.

The top level of the sensation seeking scale is thrill or adventure seeking. Daily the media feature stories of men and women in their "retirement years" taking up scuba diving, learning to ski, mountain climbing and taking part in exciting adventures to reach the optimal level of arousal. As the following generations of healthier, more financially secure, better educated individuals reach retirement, perhaps they will need this type of sensation seeking to escape boredom.

We all need varied stimuli and arousal to excape boredom. Too much of anything can cause boredom susceptibility. A steady diet of only delicious chocolates could soon become boring - we need meat and salad and vegetables to feel satisfied. Many older men fail to include a well balanced diet of activities as they retire. They dream of twenty-four, seven days a week of fishing - or golf - or whatever - only to find that it becomes repetitious, dull - and predictable.

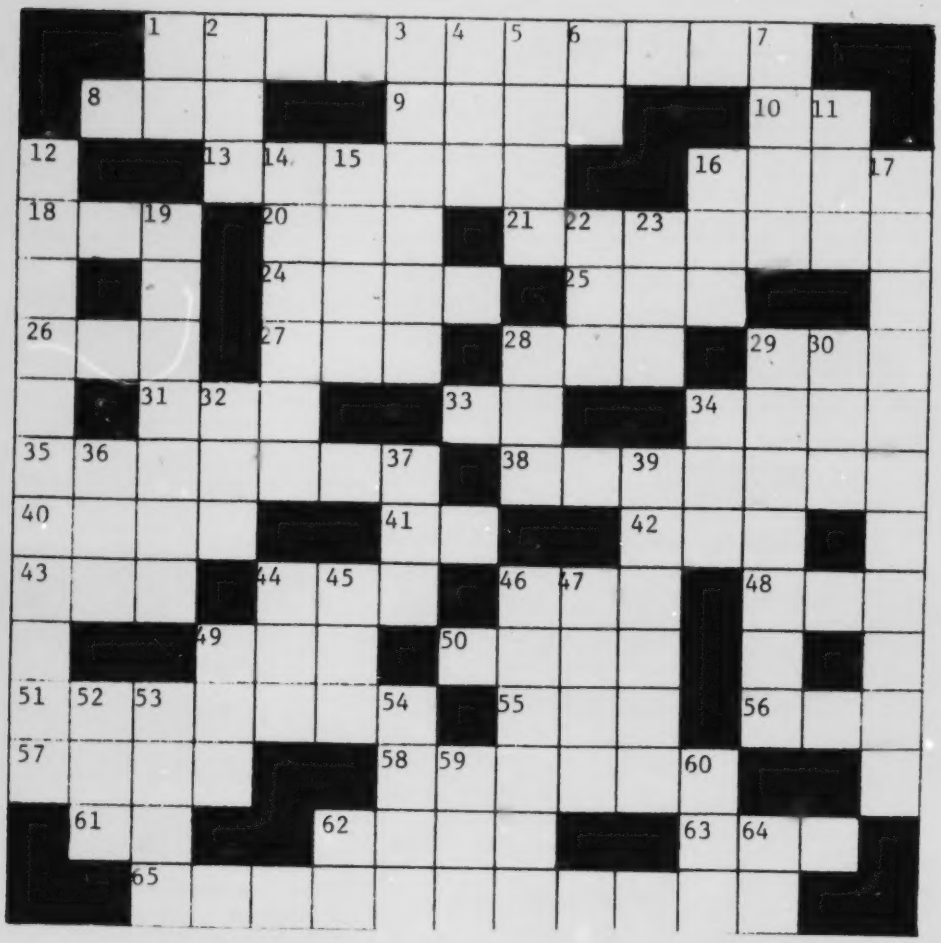
The pursuit of leisure in old age appears to seek out meaningful and useful responses to the needs of others. Older people usually have more resources than needs - and find self satisfaction by being useful. Programs are often designed to "do for" old people, when perhaps the most useful technique would be to allow a mutual interchange of services.

A new perspective of leisure may include interaction rather than entertaining. Visualize the difference in the level of arousal for a group of older residents with a) a group of young children coming into the facility, standing on a stage and singing several songs or b) a group of young children joining the residents for an Easter egg hunt of eggs which the older people have decorated and then teaching each other some songs of "their generation." The balance between boredom and tension includes opportunities for interpersoanl relationships and expression of independence. Programming to include shared rather than "do for" may be the answer to many older people who find that - "Yes, my retirement years are boring."

Perhaps the repeated and rather boring statement that "Variety is the spice of life," fits for the retired leisure years. Continuing activities that have been satisfying, seeking new sensations and inter-dependence and sharing of resources might be the needed ingredients for an optimal level of arousal and escape from tension and boredom in old age.

Leisure Workshop Handout: Aging Puzzle

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE



Puzzle created by Ruby B. Carter, Hays, Kansas

Make a large puzzle on poster board to use in front of room. Give each participant a copy of the puzzle questions and a copy of the blank puzzle. Work on puzzle as a group.

LET'S THINK ABOUT AGING AND LEISURE

Across

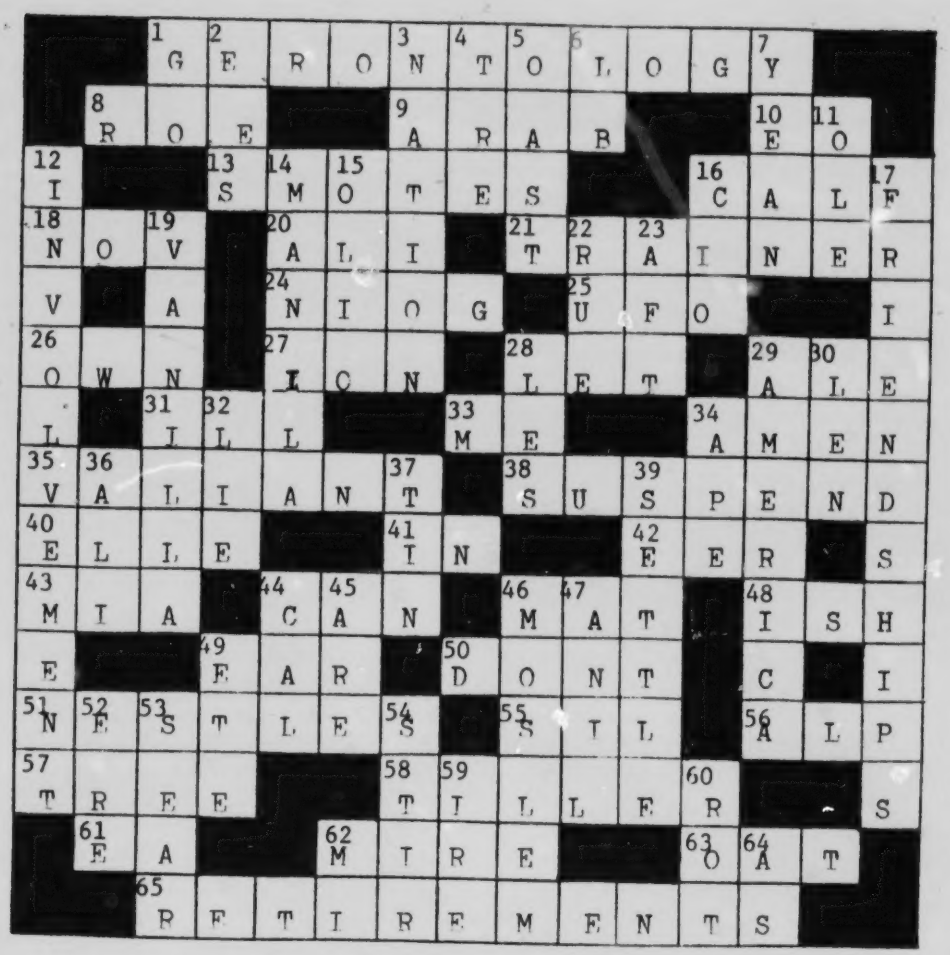
1. The study of aging.
8. Fish eggs.
9. Involved in Middle East politics.
10. First part of eon.
12. Singular personal pronoun.
13. Aging "hits" you.
16. Lower part of the leg.
18. The autumn of our life.
20. Float like a butterfly. Sting like a bee.
21. One who coaches racehorses, pre-retirement seminars, etc.
24. National Institute of Old Girls.
25. Unidentified flying objects.
26. "To be one's _____man"--to be independent.
27. An atom.
28. _____ it all hang out.
29. English malt beverage.
31. Doctors, nurses and activity directors can cure an _____.
33. Let _____ entertain you.
34. Said at the end of a prayer.
35. Captain Courageous and Prince _____.
38. Retirement: to render ineffective temporarily under certain conditions or _____activity.
40. Personal French pronoun.
41. Prefix: not.
42. Always or ever.
43. Played Peter Pan on Hallmark Theater.
44. To put up garden produce.
46. A wrestler's or gymnastic _____.
48. The last part of foolish.
49. Don't put a bean in your _____.
50. _____give up the ship.
51. She makes a sheltered, pleasant situation--or a nest.
55. One advantage of age! ___ver hair.
56. Heidi's home.
57. I think that I shall never see, a poem as lovely as a _____.
58. It's connected to the rudder on a sailboat.
61. Over ____sy.
62. To become bogged down in the _____.
63. As we age, doe we still feel our _____s?
64. What usually happens at age 65.

Down

1. Get out of sight--_____away!
2. She had b_____in her bonnet.
3. Carry _____, Kansas historical figure.
4. Italian's three.
5. Grandparents often b_____.
6. Initials of saloon on Gunsmoke.
7. Middle Eng.: to bear young.
11. Heard at a bullfight.
12. Activity, disengagement and _____ aging theories.
14. City in Philippine Islands.
15. Performed after "The Drunkard."
16. Carter is older (today than he was yesterday).
17. Some are silver, some are gold.
19. Some like chocolate, some like _____.
22. To regret, wish for a second chance.
23. Toward the back of the ship.
28. _____Brown and his band of reknown.
29. _____, love it or leave it.
30. Leonard Bernstein's nickname.
31. To speak falsely and create aging myths.
34. To imitate
36. _____Baba and the forty thieves.
37. A metallic element nearly approaching silver in color.
39. Place in a desired position.
44. Silent _____, American president.
45. Metric systen: 100 sq. meters.
47. Plant that yields indigo.
49. French: summer.
52. At an earlier time.
53. Dry or withered, as vegetation.
54. To set moving; to _____ one's self and become involved.
59. A feeling brought on by the word "retire."
60. To undergo decay, impairment.
62. Third note of musical scale.
64. Quite so/or ancient Roman copper coin.

Leisure Workshop Handout: Aging Puzzle answers

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE


1 G 2 E R O 3 N 4 T 5 O 6 L O G 7 Y
8 R O E 9 A R A B 10 E 11 O
12 I 13 S 14 M 15 O T E S 16 C A L 17 F
18 N O 19 V 20 A L I 21 T 22 R 23 A I N E R
V A 24 N I O G 25 U F O I
26 O W N 27 I C N 28 L E T 29 A 30 L E
L 31 I 32 L L 33 M E 34 A M E N
35 V 36 A L I A N 37 T 38 S U 39 S P E N D
40 E L L E 41 I N 42 E E R S
43 M I A 44 C 45 A N 46 M 47 A T 48 I S H
E 49 E A R 50 D O N T C I
51 N 52 E 53 S T L E 54 S 55 S I L 56 A L P
57 T R E E 58 T 59 I L L E 60 R S
61 E A 62 M I R E 63 O 64 A T
65 R E T I R E M E N T S

Group Exercise and Discussion

The Creative Leisure Aging Puzzle

Procedure: As a group, solve the leisure crossword puzzle. Discuss the significance of the words to leisure in later life as the squares are filled in. Example:

56 across - Heidi's home - Alp - could be travel, re-reading beloved stories, sharing stories with young people

How do we creatively use leisure in our later years? Perhaps one idea would be to do a little generational shuffling of roles--let young people take brief sabbaticals from school and work--and adults take brief sabbaticals from work and go back to school. Both would benefit from the practical experiences and the academics and perhaps could learn to use leisure creatively.

An Aging Puzzle -- Group Exercise

Leisure may be defined as "a time for a particular purpose" or as "freedom from pressing necessity or obligation." Work encompasses your use of time, your responsibilities, the people with whom you associate, your sense of purpose in life. Leisure time after retirement provides these same things, but within the framework of your own desires and plans.

"Time for a particular purpose" may mean time for rest, for travel, for self-expression; a time to enjoy hobbies and recreation, to become active in community affairs, to start a second career, to share yourself with others. For many retired persons, leisure time activities are left to chance or are related to some vague ideas in earlier years that "I will do that when I have more time." For others, however, leisure time activities are carefully planned and developed, and are often an extension of activities enjoyed in earlier years. Spending time is much like spending money--you get more out of it if you plan carefully.

In evaluating a program of leisure time activities, there are four guidelines to follow.

1. Continue and develop more than one kind of activity.

2. Be aware of one kind of activity that you enjoy doing by yourself--and at least one kind that requires group participation.

3. Anticipate changes in physical health, finances, geographic location, primary relationships which might affect your leisure activities.

4. Be aware of things that bring you satisfaction and set objectives for yourself to realize this self-satisfaction, such as learning something new, visiting friends once a week, etc.

Leisure today is all around us, at home, downtown, at the senior centers, at the lake--everywhere. There are hundreds of activities one might want to engage in and that is one of the problems. Like the little boy in the candy store with a nickle (maybe fifty cents in these days of inflation) which goodie should we choose?

Hobbies can be fascinating, fulfilling experiences--or they can become dull, meaningless excuses for leisure time activity. How often we hear the expression, "All one has to do to be happy in retirement is to have a hobby." Not true! Hobbies, in any shape or form, may not be the answer for some people, but if you are interested in a hobby--let it be meaningful for you, and try to be creative as you develop it.

For example, collections can be simply an accumulation of "things," or a collection can become a vibrant experience by following one or all of the following suggestions:

a. Be selective. Just because you collect cups and saucers, you need not buy every one you see. Select a theme--one from each state or country, cups with pictures of people or places, cups representing special events, etc.

b. Find an attractive way to display the collection. An older lady in a small town in Kansas had a collection of buttons--hundreds of buttons of many sizes, colors, materials. Instead of leaving them in boxes, she created lovely "Pictures" using brown, yellow, and orange buttons to make a beautiful butterfly; shades of blue buttons were used for bluebirds sitting in a tree of green and brown buttons; brown buttons made "The Little Brown Church" and she created many lovely floral pictures.

c. Learn more about the item you collect. This may be done individually or by joining others who collect the same thing. Study the history, or the geography, or the art value of your "collectible," but learn as much as you can about it.

d. Share your collection with others. Depending upon the nature of it, there will be clubs, school classes, nursing homes, church groups, etc. which will enjoy seeing and hearing about your collection.

e. Earn a little income from your hobby. Again, this will depend upon the kind of collection and your interest in buying and selling.

Education can be exciting in later years. Put all those years of experience, solving problems, mastering tasks to work for you. Adult learners have more fun in learning just for the pure joy of it. The "traditional" student may be goal or job oriented and "learning" to fill in the proper requirements for a degree. The non-traditional or older student can take astronomy for the simple pleasure of studying the heavens--and not worry about the physics of it all unless they really

want to. Individual and group learning experiences can range from formal studies of ancient literature to informal shared cooking experiences. One certainly doesn't need to retire from learning--it's a lifelong process.

Volunteering and serving others can become almost a second career for many older people. The satisfaction of sharing your skills, experience and personal energy can be threefold.

1. You may be helping people whose needs otherwise would not be met.

2. You are making your own personal space in life a better place for others.

3. You achieve a sense of dignity and self-worth.

Every community runs on volunteer power. Volunteer brokers like the Voluntary Action Center can help you find a slot that brings you that warm glow. And why not get that volunteer habit while you're still working? Then when you retire, you know you have a satisfactory role that you can maintain or expand.

Spectator sports, active sports, travel, mutual interest groups--the list of leisure activities could fill a book--and do. Whatever you include in your leisure program, remember, they should result in relaxation, enjoyment, growth and a sense of fulfillment. Plan ahead for your leisure as carefully as you plan your financial and living arrangements for creative use of your leisure will enhance everything else.

Bill Green's enthusiasm for pottery keeps growing. Here he works at his potter's wheel on a shady patio.

Pottery for pleasure

By Bill Green

At 65, I'm just starting to explore the limitless field of pottery, where the opportunity for creativity and freedom of expression are infinite. It's a pleasant and inexpensive hobby. Best of all, any one can do it.

Too many projects designed for older people are either noncreative or semicreative. Painting by numbers? Coloring other people's ceramic figures? Nonsense. Get into potterymaking.

Start by visiting a potterymaking class or workshop. Take a piece of clay. Hold it. Mold it. Press it. Get the feel of it. Soon, you'll want to transform this ordinary piece of clay into an object of beauty and usefulness. Now, for an experiment, place the clay on the wheel. As it turns, shape the clay as you wish. Push in a little here with your thumbs; spread out the top with your fingers. Watch it slowly take the form of a bowl, a cup, a pot—a custom-made object created by you.

How to find available classes or workshops? You should have no trouble if you live near an art center, college, or adult education facility. Try to enroll in a beginner's class—one that's free or low-cost; a premium-priced course is probably more for the professionally inclined student.

If you can't enroll in a class immediately, ask to audit one. By being on the scene, you'll soon know when there is a vacancy. You'll also widen your circle of friends and meet others who are interested in pottery.

The hobby or craft stores where you'll purchase your supplies will be good sources of information. In addition, they'll be able to direct you to local classes and to places where you can have your completed works fired and glazed.

Books on the subject are readily available at your local library.

However, by actually participating in craft classes you will learn more quickly and enjoy the activity.

Having done some research and observing, you'll be eager to try your hand at the wheel. Clay is a malleable medium. You can form it, crush it, re-form it and use it over and over. Practically every scrap can be used, so there is little or no waste.

Very few pieces of equipment are needed other than the potter's wheel—you can use the school's and later get one of your own. A knife, loop, spatula, shaping tool, sponge, and a few pieces of scrap wood for texturing are sufficient.

I use an inexpensive wheel that is compact, sturdy, simple and portable. I can move it outdoors when the weather is nice or use it in almost any room of the house. When not in use, it can be easily stored in a closet. The wheel meets my needs as an inexperienced potter and will probably serve me well for many years.

Since all work on the wheel starts with centering, you may want to purchase an accessory that will help you accomplish this with little effort. Unless you start with the clay centered, nothing symmetrical will result. But if this happens, don't stop—just do your best and see what develops. If the pot collapses or gets too far out of shape, begin again.

Later on, you'll require the use of a kiln for firing and glazing. Here you'll be introduced to the wonderful complex world of glazes—the lovely, shining, crystal-hard color that gives pottery its distinctive beauty. Be sure to seek out specific recommendations when you get to this phase of potterymaking.

In time, you'll find which kinds of pottery objects suit you best—whether a tall, graceful vase, a rough textured bowl or whatever.

I was so pleased with the first bowl I made, I decided to glaze it purple. I thought it looked gorgeous and I still do. So does my wife. And when she serves green beans in it from her own garden, we both glow with satisfaction.

You may start with the simplest dish before going on to more intricate items. But you can be sure that, whatever you make, you'll have the satisfaction of having created it yourself.

Video Presentation

More Than A Gold Watch

Retirement from a work role does not mean withdrawal or individual disengagement. Many opportunities are beckoning the retiree with creative time on his hands.

One possible pathway that deserves some consideration is adult education - or you are never too old to enjoy learning something new. The video presentation produced by KTWU for "Washburn Insight" highlights four older scholars involved in a self satisfying learning experience on the Washburn campus. Four separate rationales and objectives are identified as the impetus that brought these Senior Ichabods back to campus.

1) Skill enhancement and relationship enrichment - a retired merchant.

The student's life long creative artistry is enhanced by participation in a metal craft or jewelry making class. Beautiful silver, lasting bracelets, necklaces, rings, etc. can be designed and created and given to family members and friends - satisfying that basic aging need of generativity. The joy of exploring possible gifts to his children - and the pleasure of the children finding gifts of tools, silver, stones that they might give to him are rewarding for several generations. The stone that the son might give his father to make a ring for a granddaughter - that she in turn might pass on to a daughter - increases pleasure one hundred percent.

2) Adding to an accumulated store of knowledge and pursuing special interests - a retired secretary.

Life long interests and bits and pieces of stored knowledge can be enhanced by academic pursuits. Learning is a fundamental strategy used by mankind in coping with life experiences. Enrichment of established skills and knowledge can be the pleasure of later years. The study of astronomy, geology, archaeology for the pure pleasure of knowing more about the world around us - and finding that we are a part of that great design - can open new vistas and bring a deep and lasting sense of self satisfaction.

3) Dispelling myths about adult learning capabilities - a retired owner of a small business.

Intelligence and memory do not fail and decline in advanced adulthood. Research has often used cross - generational studies that have compared twenty year olds and eighty year olds - or apples and oranges. Older adults, given the opportunity can be extremely perceptive students. Because life experiences denied many individuals now sixty five years of age an opportunity to go to college and get a degree - it can become a golden grail - a much sought after goal. Proving that you can "make the grade" can be a powerful stimulus and enhance the self concept and self esteem of the older learner.

4) Adapting to change and maintaining outside stimulus - a retired social worker.

Physical immobility can be an enemy to an aging individuals and reduce the opportunities for mental stimulus and spirited interaction with others. Escape from this trap can be the challenge that brings an older scholar to adult learning opportunities. Living in an institution that administers health needs limits the number of outside activities that are available. Educational television can bring enrichment to the adult learner's bedside and provide structured mental exercises that not only add to the store of knowledge, but may through the mental stimulus, aid the physical well being of the individual.

Older learners have varied reasons to utilize adult education opportunities as a possible creative use of leisure time in old age. Just a beginning list might include -

1) An education that could be directly related to the immediate concerns of daily life such as
   a) health related topics
   b) consumer education - legal advisement
   c) family role conflicts and adaptations
   d) personal self awareness

2) An education that pursues avocational interests and the pure joy of learning
   a) a doctor now able to study music
   b) a musician now able to study medicine

3) An education as esthetic appreciation - mature people no longer so concerned with basic survival techniques
   a) Grandma Moses learns to paint
   b) the task oriented "doer" learns to appreciate music

4) An education for skill development for perhaps a second career
   a) the hobby may turn into a business and need some managerial skills
   b) the "empty nest housewife" may enhance her skills and may desire to continue to nurture and become a nurse - or a social worker

School Was Never Like This!
Elderhostel Program

Hostelers, left to right, Fred Bannon, Helen Flower, Robert Blyden, June Lannon and Leonard Young spent a week at Washington State University in Pullman taking courses that enriched and broadened their knowledge in several fields.

Photos by Lois F Gensler — Courtesy Atlantic Richfield Company

For the fifth year in a row summer school will mean summer fun and enrichment for older Americans participating in the Elderhostel program. This is a unique series of on-campus educational programs offered to men and women over the age of 60. The popularity of the program continues to grow and this year courses will be taught on 235 college or university campuses in 38 states.

Courses begin at the end of May and continue through Labor Day. Sessions run for a week at a time with two or three categories of fered during each session.

For many, the Elderhostel program is a different kind of vacation and recreation that reaps untold benefits at a reduced cost. The maximum cost for a week in any of the programs is $115, some are less. This includes room, board, tuition, and extracurricular activities. While on campus the hostelers live in student dormitories, eat in the school's dining facilities, and take up to three undergraduate courses of their choice.

Since the schedules are so varied, veterans of the program often plan an entire summer of educational enrichment. They travel from campus to campus studying courses that interest them. Last season one Iowa woman is said to have completed programs on 10 different campuses.

Almost all participants express satisfaction with the offerings. Once minor mental adjustments are made to dormitory-style living, the broader picture emerges—that of expanding the mind.

Programs are not restricted to stereotyped subjects thought to appeal to the older person. Instead, one can indulge in such fields as repertory theater, music, advertising, religion, foreign languages, worldwide economics, current issues in education, politics, medicine, crafts, nutrition, man and his environment, dancing, exercise, grooming, and an infinite number of others. All courses are taught by regular faculty members.

Not only does the student benefit, so does the host college or university. The Elderhostel program is operated on a nonprofit basis and most of the fee goes to the sponsoring school. Only a nominal amount goes to Elderhostel for administrative services.

Formerly prospective students had to contact regional offices or the schools involved, but this year the process has been simplified. Now there is a national catalogue and registration system that will provide information and registration for all Elderhostel programs.

For information and the catalogue write, DO NOT CALL, to: Elderhostel, 55 Chapel St., Room F, Newton, Mass. 02160. □

Older students go right to the source for updated information on commercial dairy farm management.

Use of complex laboratory equipment like this electronic microscope is demonstrated in a science course.

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SOCIAL GERONTOLOGY WORKSHOP
UNIT #2
GERONTOLOGICAL MENTAL HEALTH

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 123, Benton Conference Center

CS 313D
The Impact of Ageism

Resource Leader: Thomas Dolgoff, Organization and Management Consultant, Center for Applied Behavior, The Menninger Foundation, Topeka

SESSION #8

Suggested Agenda

Introductory Lecture:	The New Ism - Ageism
Lecture:	Change and Stress in the Middle and Later Years
Lecture:	The Crisis of Retirement
Group Exercise:	Managing Retirement Stress
Feedback and Evaluation	

Objectives

1. Increase personal awareness of our own age prejudices and the impact of ageism.
2. Present materials relevant to life stages and the conflict in task development as we age.
3. Present materials pertaining to the changing roles of the middle and later years.
4. Increase awareness of personal and societal strategies for change and growth possibilities in the middle and later years.
5. Discuss the stresses caused by the crisis of retirement.
6. Discuss the multiple solutions to respond to the stress of retirement.

Introductory Lecture

The New Ism ---- Ageism

"Certainly a man isn't fit one day and unfit the next because one page of the calendar has turned." Dr. Theodore G. Klumpp

Who are these people growing old? And, who are these people who are guilty of ageism? You may not realize it, but we all are. First of all, what is ageism? You probably won't find it in the dictionary, for it is a term coined by Dr. Robert Butler in 1968. A general definition would be: Ageism - prejudice and discrimination leveled by one age stratum against another. Ageism, or the discrimination on the basis of age, can oppress any age group. If you are young, you may have been told that you are inexperienced, too immature, too untested. You may have found that in job hunting you were told that only experienced employees were wanted and to come back when you have some experience--and you wondered how you would ever get any experience if you had to have some before you got some. If you are old, you may be told that you are out-of-date, old-fashioned, behind the times. You may have lots of experience on the job, but because of your age, promotions might go to younger employees who might be perceived as having a "brighter future."

"It is not by muscle, speed, or physical dexterity that great things are achieved, but by reflection, force of character and judgement. In these qualities old age is not only poorer but is even richer." Cicero

The phenomenon of ageism is complex. Social gerontology is affected by demographic changes, increased life expectancy, changing family patterns, industrialization, urbanization, greater mobility and advancing technology. Let's briefly examine some of these social forces and their effect on older individuals and the creation of ageism.

Our western cultural heritage places the values of work and financial success high on the scale of individual worth. Industrialization reinforces the high value of productivity with more being better. As we struggle to keep up with all the new discoveries and update our skills, older people may feel that they have a built-in obsolescence. As one observer stated, "The old are like cars. When there is a new model that runs faster and looks great, we trade in our old cars. It's easier to replace them than it is to fix them up." Or, it's easier to hire a young, strong worker than it is to retrain an old worker. Ageism causes some older workers to throw in the towel and give up a fulfilling work role to a life of dissatisfaction.

But, we might adopt a "plan ahead" attitude. "We can't cross a bridge until we come to it: but I always like to lay down a pontoon ahead of time." Bernard Baruch

Our frenetic pace and tempo of life also has its effect on ageism. We rush from here to there, we shoot rockets into the universe, and society swirls around us at a "fast food pace." One of the things that happens to us normally as we age is that we experience a loss of energy. We can no longer run for as long and as far in keeping up with the Joneses. How many of us have been guilty of silently (or on occasions loudly) cursing that slow, old driver who is keeping us from our destiny? Or, the older woman in the check-out lane at the grocery store, who takes a bit of time to talk to the checker and may not have her money ready as the food quickly disappears into the brown paper bags. Older people are operating on the "walk signals" and sometimes a society that operates on the "run signal" bumps into them as obstacles and curses them for being in the way.

Not only is our pace rapid, but the changes that have occurred since 1900 are staggering. My values are significantly different from my parents' and my children's--and my grandpartents' values are a whole lot different from my grandchildren's--and that's all within a 80-year span of time. Of course, my values are the right ones, and all you need to do is to ask someone my age to reaffirm them. We all value processed in different historical settings, and the more history we've seen, the more change and conflict we might experience. Take the value of patriotism for example. I value processed during WW II and everyone was super patriotic--everyone did their bit to save the world for democracy--the men went off to the war to end all wars, the women went into factories, and children collected scrap metal to make into guns. My children value processed during a different war, the Vietnam war, and they didn't need to collect scrap metal. They had the conflict with their cartoons and morning breakfast cereal and saw what it was like for young men to engage in armed conflict. When values clash, ageism can arise with each age group prejudiced against the other.

If ageism is a social problem, it is largely one that society created. Old age is viewed as a time of physical ugliness, sadness and sorrow, loneliness, boredom and poverty. But perhaps we can put aging into perspective.

"To be seventy years young is sometimes far more cheerful and hopeful than to be forty years old." Oliver Wendell Holmes

Lecture

Change and Stress in the Middle and Later Years

"For everything there is a season, turn, turn, turn;
And a time to every purpose under Heaven,
Turn, turn, turn."

This song, performed by Judy Collins, expresses the challenge that there are distinct characteristics and tasks for each period of our lives. We are products of our past, and need to remember and understand what has gone before to sense our own growth and development in our ever blending stages of life. We use our yesterdays, joys and sorrows, to live today and tomorrow. An old saying expresses the need for looking back, "Those who cannot remember the past are condemned to repeat it."

We all experience tasks and conflicts at each stage of development in our life cycle. How we accept the conflict and tasks affects our ability to age successfully and find a fulfilling role in later years. Eric Erikson defines eight stages of life and the strength developed at each stage of development that might be useful to explore as we seek to understand and accept our own aging.

1. Infancy. Trust vs. mistrust

The human baby is born absolutely helpless and is intimately aware of fear, helplessness and dependency. He cannot survive in his environment without depending on others to feed and nurture him. He learns trust or mistrust in that environment--will there be a response to his hunger needs, his need for companionship, or will he find frustration, anger and seek manipulative means to survive?

2. Early Childhood. Autonomy vs. shame

As the child begins to explore his environment in his first years, he begins doing things for himself. Moving his body from one spot to another in order to satisfy a need begins to make him less dependent. If he fails at a task that he sets for himself, or which his nurturers set for him, there may be a sense of shame and guilt. Being able to please himself by securing small needs satisfactions can create a sense of autonomy and allow him to start the life-long process of discovering himself and how he fits in the world around him.

We can begin to see the conflict in old age of losing this autonomy that can bring a sense of shame and guilt as the body will no longer respond adequately and one becomes dependent on others to meet intimate needs.

3. Play Age. Initiative vs. guilt

Complete trust or mistrust in our surroundings and of others are not ideal behaviors. A child must learn from the successes and

failures how best to interact with his environment. Indian children are given great freedom, but they are given two don'ts--Don't go near the edge of the cliff or too near the fire. There are certain elements in our world that we need to be aware of; that can cause us pain and unhappiness. We should not trust the elements in our environment that can hurt us. We sometimes only learn trust by experiencing mistrust, by experiencing a measure of comparison of what satisfies our needs and what brings us hurt and displeasure.

4. School Age. Industry vs. Inferiority

In primitive time, humans needed to work to survive. During this developmental cycle, the individual learns the value of work and what his relationship to work will be. A child that is given everything and that has not had to exert either physical or mental energy to experience satisfaction, may not be motivated to use his own work to achieve his goals. He may find that he can use others to bring him pleasure and depend on others for his life satisfaction. The individual that identifies work or industry as a major value in his development, may experience pain and discomfort in retirement and the accepted work role is no longer available to him.

The conflict of no longer working in a paying position can cause feelings of inferiority if appropriate alternatives for this basic need are not discovered.

5. Adolescense. Identity vs. Identity Confusion

The multiple stimuli that assault us is inconsistent and unpredictable. How can we best identify our central feelings and learn how to best cope with our environment? The confusion of teenagers searching for their identity can sometimes be sensed in older individuals as they experience late blooming and start on journeys of self discovery in later life.

In our fast paced society, it is difficult for individuals with high levels of energy and multiple outside interests to maintain a secure sense of identity. Visualize an older individual that has experienced a stroke and how the changed environment caused by physical handicaps might cause an identity crisis.

6. Young Adulthood. Intimacy vs. Isolation

The need to establish relationships with others on an intimate level often culminates in marriage, and the seeking of understanding, intimate relationships with peers and others. This need continues in later life but is often difficult to fulfill with death of a spouse, peers and siblings. As one maintains their identity, it is helpful to have a mirror, or a confidant that can reflect back and give the kind of feedback that reassures and makes an individual feel whole and right with his world.

7. Maturity. Generativity vs. Self-absorption

The need to create and leave behind a legacy seems to be strong in mankind as they reach the middle and later years. The child rearing tasks are completed, and the nest may be empty, but the need to nurture and guide the next generation continues. Older individuals seem to receive a sense of satisfaction in teaching, or being a mentor for a young career person. The need to continue to make a contribution, either in the political arena, or by simply creating material items to give to children and grandchildren satisfies the need for generativity. Individual disengagement theories have been postulated because of some older individuals self absorption, or withdrawal from society and into themselves. They may or may not have the avenues of creativity available to them, and turn inward and away from society as a whole.

8. Old Age. Integrity vs. Despair, Disgust

We either like ourselves or we don't in old age. As Ageism assails us and subtly tells us that our old appearance is bad, that our non-work role is bad, that our loss of personal status is bad, some older individuals sink into despair and self hatred. Others develop a sense of "the tribe elder," with an ability to utilize the life experiences and problem solving skills to accept themselves and others, and try to leave the world a better place for future generations. There is a strong drive to find meaning in life and to ask "How did I live my life, did it make any difference?"

Each of these stages affects our aging process and how we deal with our mid-life and later transition. The use of chronological age is an inaccurate measure to judge the "age" of a person. Characteristics of the mid-life transition or middle age include:

1. An awareness of physical change, a decrease in energy level and a loss of youthful beauty.

2. A realization that there are more yesterdays than tomorrows.

3. Admitting that if our dreams are not fulfilled by now, they are likely not to be, as that we may need to give up that dream and re-prioritize.

Self questioning takes place with the question of "Is it worth it?" "Have I done with my life what I set out to do?" "Am I happy?" Middle age woman may find conflict as her children leave the nest, and she tries to re-establish relationships with her husband and useful ways to spend her now empty hours, she may have difficulty with her self identity. She has been "Johnnie's mother" and not an individual with diverse interests. Other women that have devoted some of their energy to a career outside of the home may find that they are now "out of phase" and in conflict with their husband's career. He started young and may be winding down a career and preparing for retirement, and she is just beginning to advance.

Another mid-life crisis faced by both men and women is the death of a parent. Guilt of things left undone, nostalgic memories of childhood and the "good old days' and the loss of parental emotional support may be significant. All of these crises can affect the mental health of middle age people and coupled with the way they are reacting to the eight stages of life may interact and cause some dissatisfaction and unhappiness among older individuals.

There seem to be four polarities in the middle and later years that confront us: youth/age, creation/destruction, masculine/feminine, and attachment/separateness. The task is to find youthful ways of being old, and mature ways of being young. Society is beginning to see the wisdom of allowing youth time to work while they are still learning, and allowing older individuals to go back to school and learn new skills while still working. Creative opportunities for expressing anger and frustration are few, but as advocacy for human rights expands, the older individual's creative use of his life experience can benefit all of mankind and not be a destructive force directed at his self esteem. As individuals age, the masculine characteristics tend to become stronger in women and the feminine characteristics stronger in men. Older men are allowed the luxury of being sensitive to young children in a loving grandparenting role, and older women are encouraged to become the "speaker of the house" in political advocacy. The awareness of mortality causes a disengagement process or separateness by some, as the realization that they and their peers are closer to death than to birth. Others, may be able to establish deep, satisfying relationships or attachments with families, peers and friends because they are aware of their mortality and wish to live each day fully.

In addition to these polarities, there are five general characteristics of an aging person.

1. A change in the sense of time. The realization that there is not as much future as past and the desire to make some order out of their life span. A time spent looking backward and reminiscing instead of future planning.

2. A tendency to life review. Looking back at personal experiences and personal relationships and trying to relate them to the present. "What have I done with my life? Would I do it over again the same way?"

3. A need to make amends. The settling of old accounts. A time when the ledger should balance in life deeds, with hopefully more on the good side. Individuals slighted years before are suddenly remembered and efforts made to right a wrong.

4. A transmission of power. A sense of wanting to pass the baton on to someone who can continue the race, the process of letting go and letting the younger generation take over.

5. The desire to leave a legacy. The feeling that a bit of you will be immortal if your knowledge is shared with someone, and that perhaps they will share that same knowledge as they age.

Eric Erickson, perhaps wanting to leave a legacy, rewrote his life cycle chart at age 80, and added strengths that are acquired and carried on to the next stage. His additions to the list make a much more positive outlook for aging and include:

1. Infancy; hope and faith
2. Early childhood; will
3. Play Age; purpose
4. School Age; competence
5. Adolescense; fidelity
6. Young Adulthood; love
7. Maturity; care
8. Old age; wisdom.

But what good does all this awareness of aging do if we still do not know how to cope with the crisis and stress of aging. Fortunately, there are a few strategies for change and growth in the middle and later years that creative minds have discovered for us. What can individuals do? You can:

Re-examine your goals and values. Are they really yours? How have they changed? Are they consistent with your priorities?

Take responsibility for your own behavior. If change is to occur, it must start with you and is not the responsibility of "them."

Invite and accept reliable feedback. A confidant to mirror your behavior can be useful and help you maintain good mental health.

Get in touch with your feelings. Search through the clues and solve your identity crisis. Separate out the roles of "I am John's wife, I am a nurse" and look for less self-limiting identities.

Find new sources of gratifications to compensate for inevitable losses. Personal satisfaction can be obtained in high engergy and low energy pursuits, and the individual that has a large "portfolio" of alternatives can weather a possible physical immobility with less stress than one who has no alternatives.

Respect your body. Take care of yourself physically; exercise, eat wisely, keep in touch with aches and pains and seek treatment. The body and mind are indivisible and physical illness interacts with your aging mental health.

Become a mentor to a younger person. Passing on information and seeing the personal growth of an individual may satisfy multiple personal needs.

Actively seek out others in your situation and enter into group discussions to mutually share problems and resources.

Set realistic and attainable objectives. Don't try to do too much too fast.

What can society do? It can:

Provide opportunities for activities that tap the need for generativity such as teaching, consulting, advising and mentoring.

Establish "job change" or "career change" clinics.

Offer and encourage multi-generational and special physical fitness programs.

Research pensions, social security and retirement income supplements to adequately meet the needs of spiraling inflation costs.

Remain sensitive to the changing needs of older individuals and the unique resources that they might contribute to society.

None of us may be able to clearly identify all the stages, phases, cycles and tasks in our individual aging process, but the good news is--

We have choices.

Lecture

The Crisis of Retirement

Any change in our lives will usually result in a crisis. That is, it will bring some stress into our lives and the need to develop some mechanism for coping. Retirement imposes a number of stresses, and everyone entering or approaching that period of life should be aware of certain facts in order to avoid serious trauma:

1. Retirement is one of "the facts of life" in our society today and cannot be avoided simply by refusing to think about it.

2. Retirement will bring with it many changes, adjustments, and some stress.

3. The retiree is almost certain to have some feelings about this change--perhaps positive, perhaps negative, probably both.

4. There are techniques for dealing with the feelings in such a way as to insure good mental health.

It is not too difficult to understand the crisis of retirement when we take a look at the meaning of work. True, we work for the security which the job provides in terms of money for food, housing, clothing, recreation, etc. But the job also provides identity--we invariably ask a new acquaintance, "What do you do?" meaning "What is your job?" We utilize this technique to find out a lot of personal data about the individual and identify him with a role. Along these same lines, the job provides status, a feeling of being useful, and a sense of independence. It defines the use of time each day, the people with whom we associate, and often is the source of friendships which carry over into social situations. When the employee retires, he suffers losses in most of these areas. Even with an income which provides a reasonable degree of security, he may still feel threatened because of the possibility of inflation or unexpected expenses. He has lost his identity as a chemist, teacher, plumber, executive, etc. and may feel that his only claim to status is in terms of what he did when he was working. He will have a stretch of time, from 8 to 10 hours each day, which was formerly used on the job and getting to and from work, and he may be faced with the dilemma of how to make use of this time. He will not be seeing his associates on the job every day--perhaps not at all. He may not have liked all of them, but they were there! Unless he has already become interested and involved in other activities, he may experience a deep sense of worthlessness. All of these losses tend to produce some degree of anxiety, perhaps feelings of fear, resentment, anger, or depression. For some people, there will be feelings of relief, joy, anticipation, but even these people will probably experience some degree of stress as they begin to cope with the changes.

A second cause of retirement stress is the fact that it is related to the phenomenon of growing old. Although recent years have brought some improvement in attitudes about aging and old age, we are still caught up in some of the myths which proclaim that to be old is to be physically

disabled, mentally deteriorated, sexually impotent, socially isolated, dependent, politically uninvolved, useless, sad, etc., etc. The rewards in our society are for achievement, speed, beauty, power--it is more important to do rather than to be. We are beseiged with propaganda which tells us how desirable it is to be young, to "think young," to look young. "Hate that gray? Wash it away." We can scarcely give any credence to Santyana's lines which proclaim:

> "Like a candle set in a holy place--
> So is the beauty of an aged face."

No--the greatest compliment we can receive is to be told that we do not look our age!

Even the people who are engaged in the so-called "helping professions" contribute to the stereotyping of older people. Medical personnel deal with the aged in terms of diseases, or room numbers; the clergy prays for the aged in the same breath with the "sick and the bereaved;" social workers get lost in the maze of case load identification and determining eligibility for services. When we deprive the older person of his identity as a human being, we may leave him very little reason for living. A local newspaper ran an article about a performance by a theatre group to which the older citizens of the city were invited on an afternoon when the theatre would be less crowded and at no admission charge. Lovely! The first line of the article states that this performance is for "the elderly, the handicapped, and welfare recipients of any age." The headline proclaims "Matinee Offered to Handicapped." Many an older person, however much interested in the theatre, would have second thoughts about being a part of such a group considered to be "handicapped" and might very well stay at home for no other reason.

How do older people cope with retirement and with the myths and stereotypes? In much the same way they have dealt with other crises in life. Some of them engage in denial, if I don't talk about it, it won't happen. Some resort to blaming employers for their own stress, or resort to anger and hostility, to withdrawal from life, and extreme depression. But most older people have within themselves tremendous resources for coping and can be helped to use those resources to achieve successful retirement. Golda Meier, at age 75, said "Aging is like being in an airplane in a high wind. You're there, so you ride it out."

Group Exercise

Managing Retirement Stress

Mental stress caused by a change in role can cause us physical illness, emotional disturbances and behavior problems. Thinking about the future, and doing a little dreaming about alternatives sometimes can take part of the stress out of these altered life roles. There are as many possible alternatives to challenges in retirement as there are individuals to dream up solutions. This exercise is designed to utilize the resources of the participant and to increase their awareness about problems and resources available for the "make-believe" older person, and to increase their own awareness of the need to think about personal retirement objectives, no matter what their age is now.

Procedure

Participants are divided into three groups. Each group is given a copy of the who's - the potential retirees. Each group is given a different set of challenges related to three separate areas of concerns, housing, health and legal. As the groups design life scenarios for the individuals, the small group records the information to be shared with the entire group. Scenarios are compared, with the mutual redesigning of appropriate and inappropriate formulas for satisfying retirement life styles.

The Who's the Potential Retirees

Jay Hardhat works for a construction firm, having worked in jobs related to construction for most of his adult years. He is 58 years old, his wife Ellen is 56, and they are beginning to think about their retirement, since Jay's company will expect him to retire at age 65. They own a two-story house outside the city limits, and have a large yard and garden. They have four children, all grown and away from home.

Janet Steno is 60 years old, has worked for 26 years as an administrative secretary for a state agency, and is single. She lives in a comfortable apartment, in an neighborhood which has changed considerably through the years, and is not close to any shopping center. She has one brother who lives in another state and they correspond infrequently. She has many friends and belongs to several social or church - related groups.

Curtis Exec, 63 is the owner and president of a thriving business concern. With his wife, Anna, who is 59, he lives in a large home in an expensive residential area. He has cash in the bank and a porfolio of investments. They have two children, five grandchildren, and Curtis has a sister whom he assists financially, Anna, who is not in good health, is completely bewildered about any kind of business management.

Where to Live?

The Hardhats are wondering about keeping up such a large house and yard when they are older. What should they do? One of their daughters lives in California and wants them to come there to live.

Janet is worried about the danger of burglary and physical attacks as she grows older. She also thinks about the need for help with household tasks, or medical care if she should become disabled. What might she do?

Mr. Exec is concerned about his wife's ability to manage a large house if he should die first. They would like to do a lot of traveling when he retires, and he wonders if they should move into a condominium or a retirement center. Any suggestions?

How Do You Stay Healthy?

Jay has added a few pounds each year until now he acknowledges that he is "a little heavy." He loves good food, and looks with scorn upon the idea of having a physical check-up. He says that he gets plenty of exercise on his job, and feels "Okay most of the time," although he finds he is often short of breath. Should Jay just continue the same routine? Ellen works daily in the garden, weather permitting.

Janet has a recurring abdominal pain and severe digestive disturbances, but keeps postponing a visit to her doctor. She says that illness is inevitable as one grows older and that "when people are forced to retire, they die soon, anyway." What would you recommend to Janet?

Curtis used to exercise at a gym and play golf, but his business takes so much of his time and energy now that he doesn't have time for anything else. He does not sleep well, and finds that he is often very tired. He looks forward to retirement, and says when they are not traveling, he will just sit around and rest. Sounds O.K.?

Is It Legal?

Jay and Ellen have their house in joint tenancy. Jay has a will which leaves the house to the four children, and Jay is sure that the children will let Ellen live in it as long as she wants to. Ellen does not have a will. Is this a satisfactory arrangement?

Janet has been dating a man from her office who is about her age. She feels that she has a comfortable savings and investment program for her retirement years, but is considering marriage to Don who has been attentive and considerate in his courtship. Don wants her to place her small estate in joint ownership "to show good faith." Janet is reluctant to do this, and Don has become very unhappy about it. What shall she do?

How can Curtis provide for his wife and the other members of his family in the event of his death?

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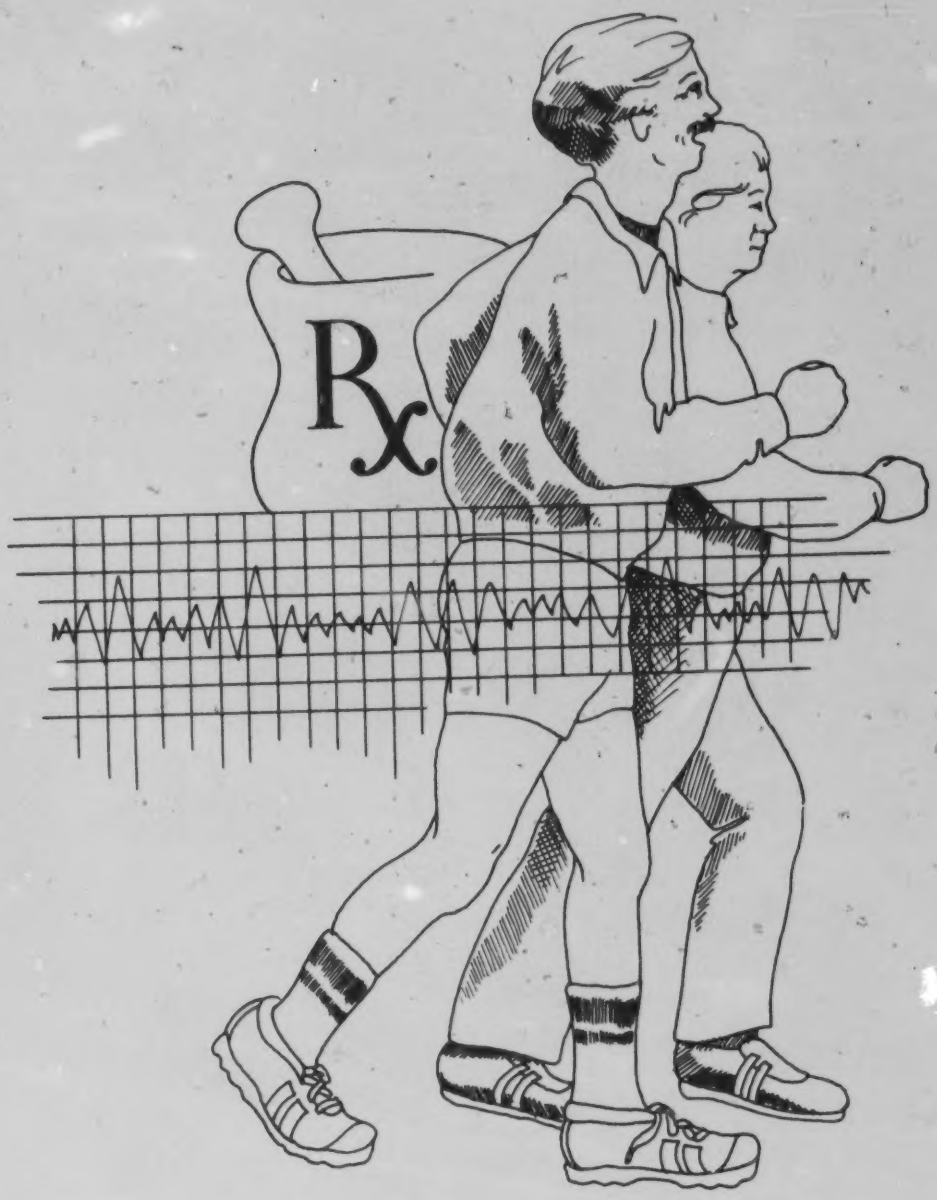
Physical Aspects of Aging



SOCIAL GERONTOLOGY WORKSHOP
UNIT #3
PHYSICAL ASPECTS OF AGING

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 124, Benton Conference Center

CS 313A
Biological Basis for Aging Human Behavior

Resource Leader: Dr. Don Boyer, Professor of Biology,
Washburn University of Topeka

SESSION #9

Suggested Agenda

Introductory Lecture:	What is senescense?
Movie:	The Fountain of Youth
Lecture:	The biological basis for aging human behavior
Group Discussion:	Can we change the basic behavior of older persons - or should we?

Feedback and Evaluation

Objectives

1. Develop an awareness of the differences of the effects of biological aging in contrast to symptoms and after effects of disease and our environment.
2. Discuss myths and anecdotal tales about aging.
3. Discuss the differences between senescense and senility.
4. Discuss established scientific research and data concerning the aging process.
5. Present information correlating the biological changes with the behavior of older individuals.
6. Discuss how this behavior caused by biological changes can affect social interactions.
7. Discuss the advantages and disadvantages of animal research.

Introductory Lecture

What is Senescence?

How many know the difference between senility and senescence? How often we have heard others (and ourselves) say, "Well, I've forgotten his name, I must be getting senile." We somehow seem to equate aging with senility, when in reality senescence is what happens in aging--always--and senility--sometimes. Perhaps putting senescence on a time line might be helpful to begin to explore the biological aspects of aging. (Chart #1 - Chronological time lines for senescence)

In Western societies, the biological concept of age governs our attitude toward what is clearly a complex and ambiguous collection of gains and losses. Our mental images of age are primarily images of unfavorable physical change. A problematic social institution such as mandatory retirement is justified as a necessary response to this biological decline. Old people's social isolation is similarly explained as an appropriate response to people whose physical conditions are rendering them socially, economically, and spiritually obsolete.

Although we may not know precisely why the body ages, we cannot very well escape the fact that it does. These changes are important for social gerontology because they represent the concrete physiological limits around which social arrangements would ideally be built.

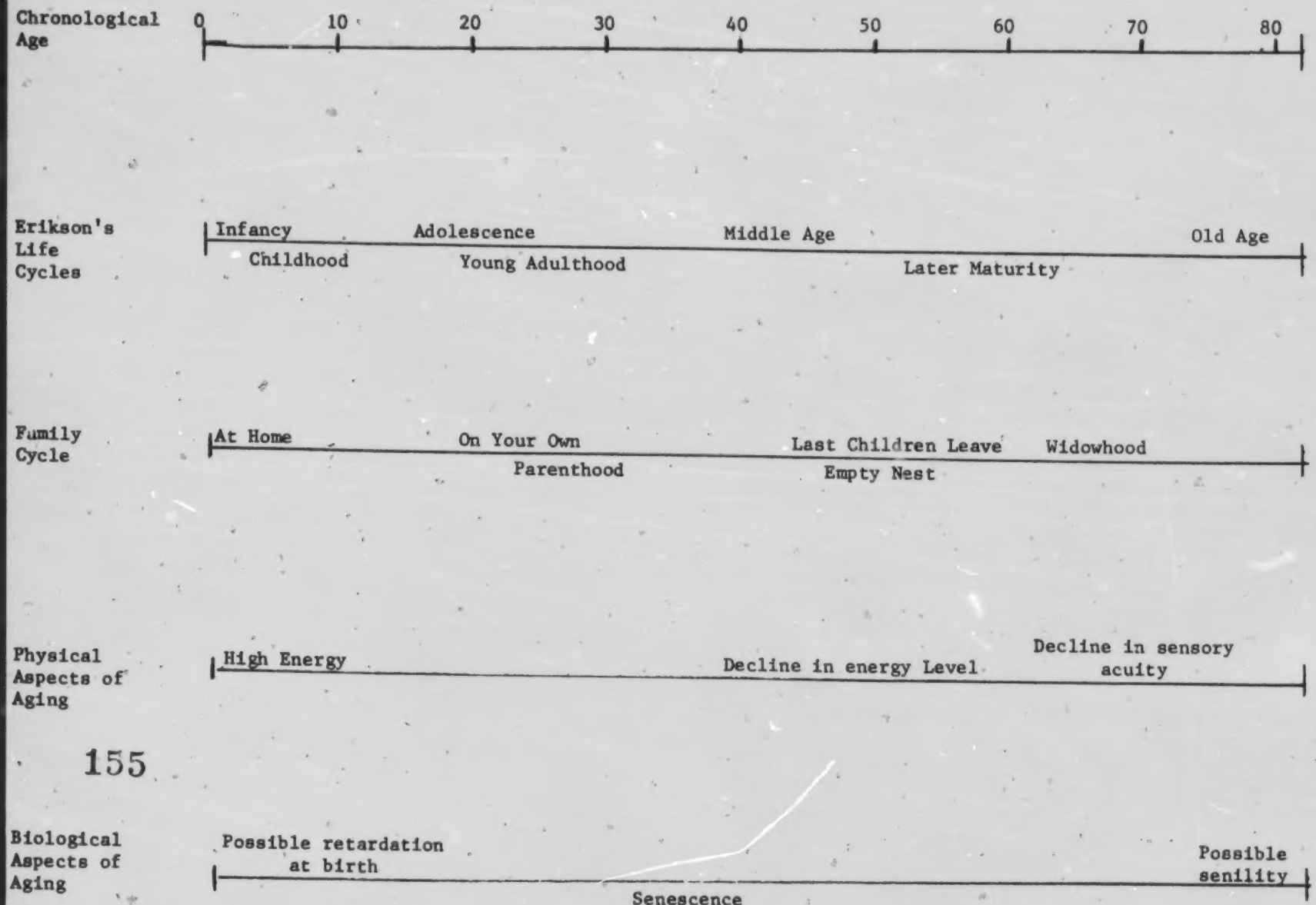
The easiest way to identify an older person is by physical appearance--wrinkled skin, gray hair and perhaps spots of dark pigment on the skin. As Dr. Karl Menninger said, "I resent the lines and wrinkles on my face for they are the public advertisement of my advancing age." Our physical appearance may reveal to the outside world the number of chronological years that we have accumulated, but the inward store of experiences and behavior patterns are hidden from view and can only be discovered by personal interaction. What we mistakenly identify as senility is probably only senescence.

Before we go on, perhaps we ought to define senescence and senility as the terms are commonly used in social gerontology.

Senescence: The group of biological processes whereby the organism becomes less viable and more vulnerable as chronological age increases. Manifests itself as an increased probability of disease, injury, and death.

Senility: An archaic term formerly used as a general term for mental infirmities thought to be the result of aging. We now know that the symptoms formerly associated with aging, and called senility, are in fact symptoms of specific, often treatable, diseases. The myth of senility is the notion that old people are or inevitably become senile, showing forgetfulness, confusional episodes and reduced attention. Unfortunately, it is a term that was used by some doctors to categorize the behavior of the old. Some of what is called senile is the result of organic brain damage, but anxiety and depression are also frequently lumped in the category of senility even though they are treatable and reversible. Old people, like young, experience a full-range of emotions including anxiety, grief, depression and paranoid states. It is all too easy to blame age and brain damage when accounting for the mental problems and emotional concerns of later life. Drug tranquilization, much overused in the United States, is a frequently misdiagnosed, but potentially reversible cause of so-called senility. Malnutrition or unrecognized physical illnesses such as congestive heart failure and pneumonia may produce "senile behavior" by reducing the supply of blood, oxygen and food to the brain. Alcoholism, often

Chronological Time Line for Senescence



associated with bereavement, is another cause. Late life alcoholism is a serious and common problem. Irreversible brain damage, however, is no myth. Cerebral arteriosclerosis or hardening of the arteries of the brain and so-called OBS (organic brain syndrome) marked by the mysterious dissolution of brain cells, are major and serious disorders that do impair human development in old age.

Aging of the human body manifests itself in various ways, only partly based on things that happen within the body. The deterioration of the irreplaceable organs and systems of the body such as heart, lungs, nervous system, liver, kidneys, of course affect the individual aging process. As one goes through the process of senescence, the human body experiences a loss of the ability to withstand disease. A strong, functioning human body has an amazing capacity to ward off disease, but with advancing age the body becomes less efficient and less capable of fighting cancer, pneumonia, etc.

As yet, biologist are not certain why senescence occurs. Numerous theories of biological aging have been expounded, and several are being tested; but none give us that magic key to unlock the secrets of aging. Progress and research in aging and senescence is accelerating and future generations may benefit from the interest of our generations. To illustrate this progress, a look back in history at a book entitled Senescence by G. Stanley Hall, published in 1922, divided life into five stages: a) childhood; b) adolescence; c) middle life or "the prime" ranging from age 25 or 30 to 40 or 45 and comprising the "best years"; d) senescence, beginning in the early 40's and before for women; and e) senectitude, the postclimactic stage or "old age proper." I know few women that would agree that senescence begins before 40--or does it. That may be just the point. In our struggle with ageism, we find it hard to admit that we are constantly aging--or in the process of senescence.

Movie

Aging: The Search for External Youth

How do people deal with aging in a culture that is largely youth oriented? The impact of ageism in our culture has evoked fear and dread in many individuals that they will lose their youthful bloom and be "put out to pasture." The "old grey mare" syndrome sends many to find treatments, surgery, potions and the fabled fountain of youth.

This film presents various ways that people come to terms with their fear of growing old and "unattractive" and an examination of the "rejuvenation industry." Spas, health clinics, beauty farms are big business, attracting both men and women in that constant search for the rainbow of eternal youth. Looking for the fountain of youth in the spa depicted in this film could be pleasurable indeed. In a beautiful setting of white beaches, gentle surf and swaying palms, this rejuvenation business' sole objective is to make people feel younger. Patients undergo cell implants, injections of lamb foetus, underwater massage, aeromatic inhalation and applications of mud, all in the belief that such treatment will postpone the physical effects of aging.

Throughout the film, various individuals discuss their attitude about their own aging and why they are searching for the fountain of youth. One well-rested executive about 40 years old, after downing a drink that contained herbs, raw eggs and other healthy potions, explained that he came for a week every year and always went away looking younger and with more youthful vigor. Another attractive lady, undergoing underwater massage while exercising her legs by raising them with physical vigor, said her children didn't like to see the fat on the back of her legs as she played tennis with them.

The film's objective seems to be to show that the later years need not be a time of depression and rejection. The choice is largely one of our own making. If you take care of your body, it will function youthfully. Just like your car, it needs a tune-up once in a while and sometimes a major overhaul.

Film available from Document Associates, Inc., 211 East 43rd Street, New York, New York 10017, 20 minutes, color.

Lecture

The Biological Basis for Aging Human Behavior

Myths concerning aging are many. That everyone ages in the same way at the same pace is a myth. Biological decline varies among individuals in its speed and its extent. One person may be biologically old at 45, another may be physically fit at 80. And, of course, not all organs decline at the same rate. Someone may have a 30 year old heart, a 60 year old response rate, 80 year old eyes and be only 20 years old.

As Alex Comfort says in Ageing: The Biology of Senescence, "Our object in studying the biology of ageing is to find out why it occurs, and whether and how it can be controlled." Increasing interest in the biological time clock has grown as the proportion of our population has increased with time. Debates on artificially extending life by altering cells, injecting hormones, surgical replacement of defective organs and limbs and mechanical life extension machines flare up with increasing regularity. Research on the secrets of aging are beginning to fill university libraries and governmental data systems. Studies of mice, fruit flies, one-celled amoeba and humans are all aimed at finding the magic key to immortality--or at least extending the number of years in the normal human life span. Some basic knowledge of this complex, ever changing discipline aids the social gerontologist to understand the behavior of aging individuals.

Let's start by discussing some of the research. The majority of research is done with animals and then related to humans. For the rather obvious reason that you can disturb the brain of a white rat more ethically than you can a human, and thereby conduct a number of controls and experimentations. Animals have some common aging processes as Sir F. M. Burnet said, "In nature, death without aging is the lot of most organisms. Man in an affluent society is the main species for which this is not true."

There are a number of biological reasons for the necessity for death. It is needed for the continuous genetic diversity and survival of the species. This can be accomplished without aging, as in some small birds where predation removes 80% each year, so that after three years less than 1% remain, there is very little aging. But fortunately, man has a better survival rate. In mammals the greater the security of the lifestyle, that is the lack of predators, abundance of food, etc., the smaller the litters, the longer the time to reach sexual maturity and the greater the life span.

There are several practical advantages and disadvantages for aging studies by using lab animals.

Advantages:

1. Mating can be controlled.
2. Production of genetically inbred lines allow fewer variables with which to deal in research.
3. Long-lived lines can be studies and bred, or long-lived and short-lived can be bred and the progeny studied.
4. The time scale of the life cycle is short in most lab animals and the entire birth-to-death cycle can be studied in a single project.
5. Environmental manipulation, including the induction of disease can be more rigorous than we would allow in human experiments.

Disadvantages:

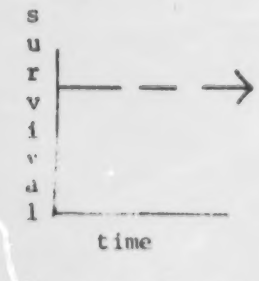
1. Pure lines are not comparable to the natural population of either animals or humans, for we are all genetically diverse.
2. The natural environment of a pure line lab animal is dissimilar from a non-lab animal.
3. While humans have many physiological traits similar to those of lab animals, their cultural and social environment are unique.
4. Only a few animals have enough known about them in enough detail to make them suitable for aging research. Most is known about rats and mice, whereas animals closer in size and evolutionary history to man would be better, such as chimpanzees.
5. Inbreeding itself reduces survival, outbreeding as in nature increases survival.
6. Different species age in different ways, or may not age in the traditional sense at all.

Some translatable results of animal research of interest in human aging include:

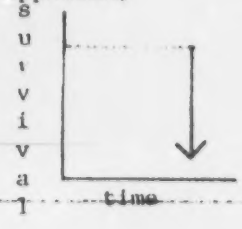
1. Males die earlier than females throughout the animal kingdom. This is not unique in humans, but seems to be biological and not the occupational hazard of the male role. In the human male there is a higher mortality rate for all ages from conception on.
2. In fruit flies, virgin females outlive the mated ones, same for males. But, in humans, bachelors die sooner than married males.
3. Fish, some amphibians and many reptiles have a variable degree of indeterminate growth or they grow continuously, but usually at a slower rate with age. The slower growing ones usually live longer. Think of the land tortoises or even the Lock Ness Monster.
4. Metabolism declines with age in humans, but is little related to age in other animals. Small mammals have higher metabolic rates per unit of weight than large ones and have generally shorter lives. But to add to the complexity, some rodents with the same size may have life spans that are twice as long. And whales live only about 30-50 years, elephants 60-70 years, hippos, donkeys, rhinos all about 50 years, and all are larger than humans. It seems that the ratio of the brain weight to the body weight correlates better with the life span than the absolute size of the body.
5. The only animals known to outlive man are some of the large land tortoises ca. 130 or more years, and possibly fish such as sturgeon to 75+.

Even with more research, we are probably not going to discover eternal life, but we may alter the mortality curve.

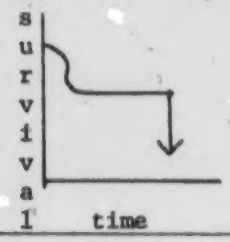
1. no aging, no mortality (doesn't occur)



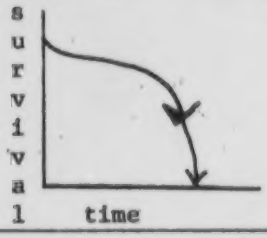
2. programmed aging only factor with no decrease in survival (this doesn't occur either, but the fewer the lethal variables the closer the approach)



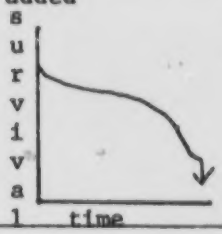
3. infant mortality added to #2



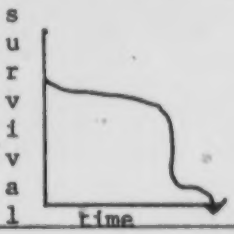
4. accidental death (predation etc., added)



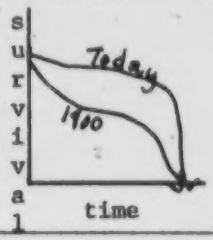
5. increased mortality with aging added



6. tenacity of survival of some aged



If we were able to remove all disease, we would not greatly extend the span of life, but simply make the curve closer to the rectangular than before.



Some of the current biological research into the causes of aging include:

A. A specific genetic program of aging.

1. Family histories show that long-lived parents tend to have long-lived offspring, but it is only a tendency and not always realized. There must be other factors at work than the lengevity genes.

2. Twin studies of MZ twins who have exactly the same set of genes show similar programming of aging development (growth, skills, emotion, intellect). One study of MZ twin males showed that they died within 10 days at age 75 of complications of diabetes.

3. Werner's syndrome: premature aging beginning in teens and ending in early death is due to a single gene pair.
Progeria: accelerated aging with death by age 11-12, cause unknown.

B. External causes of aging.

Radiation, mutagenic chemicals, pollutants, nutrition, disease from extrenal source.

C. Internal causes

Most researchers think aging is due to cellular causes which in turn cause organ systems or tissues to fail. As we age, we lose, for example, nerve cells to the brain until we lose an estimated 100,000 per day after age 30. Thus, the decreased function of cardiovascular system, respiratory system, hormonal response, renal failure cause aging and death.

Denckla thinks that aging is hormonally programmed by cells that release an as yet unidentified hormone that decreases effectiveness of throxin in maintaining metabolic rate. This theory, however, is not widely accepted.

D. Dividing vs. non-dividing cells.

Chromosomes are genetic material in the nucleus of cells. DNA are genes which copy themselves and stay in the nucleus. The result, RNA, goes out to make proteins and directs activities of the cells. The genes' action in one part of the body are different in other parts of the body. The DNA genetic material has to split to make RNA. When the DNA ceases to split to make RNA, the cells go down hill and cease to function and seem to cause the aging process. Some cells divide continuously such as skin cells, but injections, skin peeling, etc., do not prolong the life of the skin. Some rejuvenation methods that promise eternal youthfulness border on charlatanism.

1. Changes in or damage to DNA and RNA

a. DNA may fail to copy itself correctly (somatic mutation) and may fail to copy at all (cross-linking by free radicals). Alex Comfort says that free radicals are like conventioneers away from their wives--they will combine with almost anything.

b. DNA may fail to correctly make RNA.

c. DNA seems to have self-repair enzymes that may fail to function.

2. Limiting of cell divisions. Haycliff's work shows up to 50 divisions in normal cell cultures, then they quit. These cells have been frozen after 20 divisions, and when thawed go on to do 30 more, then cease. Adding certain anti-oxidants may raise division to about 100.

3. Immune system failure. Increased disease susceptibility and failure to destroy cancerous cells.

Certain studies have indicated a retarding of aging and extension of life span.

1. L-DOPA, which is used in the treatment of Parkinson's disease. When it was administered to mice in their diet, it increased their mean life span about 20% and the maximum life span about 10%.

2. Underfeeding of mice during growth period and then raising the feeding level to normal extended the life span to twice the normal.

3. Parabiosis (the natural or artificial fusion of two organisms) of young with old rats increased the life span of the older rat.

4. Cold blooded animals kept at a lower temperature age more slowl

5. Work with monkeys cooled by manipulation of the hypothalamus showed increased life span.

6. Vitamin E has been used as an antioxidant to prevent damage by free radicals and reduce mortality.

But even with all of this scientific knowledge, currently as stated by Comfort, "In man the most effective means of reducing the apparent rate of senile change are psychological, social and occupational."

Pure study and research of biological factors in aging are possible only in laboratory settings. Humans age in a complex environment with all sorts of variables in the psychological and social aging patterns. Man has developed a brain that enables him to throw the biological clock into a tailspin. He has a choice--he is able to consciously take care of his biological body, and maintain a high level of well-being into advanced age, or he can abuse the biological process by ingesting harmful elements and reduce the number of ticks on his clock.

Aging clues found

modern living

By GEORGE ALEXANDER
L.A. Times-Washington Post Service

Your chances of living to a ripe old age, accidental death aside, appears to be determined largely by just how well a particular set of genes in your body directs the repairs made to your DNA, the molecule that is the master blueprint for all your parts and aspects, according to a University of California Los Angeles professor.

The more efficiently these repairs are made, Prof. Roy L. Walford of UCLA's school of medicine told a conference last week at the National Institute of Aging in Bethesda, Md., the better are the odds of a longer lifespan. Conversely, poorly repaired DNA seems to effect a shorter lifespan.

Even our daily newspapers are showing an interest in biological aging.

The set of genes involved in this complicated process is called the "main histo-compatibility complex," or simply referred to as "MHC" by most biological researchers. These genes are responsible for the organism's reaction to foreign objects, such as tissue grafts or organ transplants, accepting some and rejecting others.

These MHC genes do this by manufacturing enyzmes that somehow "read" the DNA — deoxyribonucleic acid — in a cell. They can tell if the DNA properly belongs to the organism's self, in which case the molecule is not bothered; or if it is alien in which case the enzymes attack the foreign DNA and destroy it. This is the basis for any creature's immune system.

But these enzymes also are capable of recognizing small errors in the DNA of cells — errors that frequently crop up as duplicate copies of a single cell are made during normal growth and development. Here, the enzymes act like so many quality control inspectors, excising the damaged or incorrect snippets of DNA and restoring the molecule to its proper biochemical condition.

In a series of tests with strains of mice known to have well-defined lifespans, Walford found that the longer-lived mice have MHC systems that are considerably better at repairing their own strands of DNA than their shorter-lived cousins.

Indeed, Walford said that the mice he used in his experiments were genetically identical except for their MHC systems. He removed spleen cells from these different strains of mice and grew them in culture, preparations of nutrients and other substances vital for cell division and growth.

Assisted by Kathy Bergmann of his laboratory, Walford then exposed these cell populations to two different kinds of DNA-damaging factors — ultra-violet radiation and a drug called bleomyecin. The ultra-violet radiation causes the dividing DNA to make erroneous sequences in the molecule, while the drug causes breaks in the DNA strands.

What Walford found was that the spleen cell populations of the longer-lived mouse strains did a much better job of repairing their damaged DNA than did the shorter-lived strains. Moreover, the more efficient cells also managed to double their numbers more times than the less efficient cells before entering senescence. In other words, the better the cells were able to fix up the damage done to them, the more they grew and the longer they lived.

As for what the results of these experiments imply for human longevity, Walford said that "you can probably live to be 85 years or so just by taking good care of yourself. But to get past that, to live to 90 or more, you almost certainly need some sort of genetic advantage."

Interestingly, Walford finds parallels between the outcomes of his short-lived, repair-inefficient mice and certain human diseases like Lupus erythematosus, a degenerative condition involving the internal organs.

"We know that lupus is associated with inadequate DNA repair in humans," said the UCLA professor, "and many of its symptoms appear to be accelerated aging."

Walford has long hypothesized that the aging process results from the body's declining ability to tell the difference between self and non-self. That deterioration, which we call "aging," happens as the older body incorrectly attacks cells that really belong to itself or fails to attack substances that do not belong.

Other scientists have suggested that aging is the result of poorly maintained DNA over decades of living. Now, as a result of these mouse experiments, Walford believes that he has tied together two of the four or so major theories of the aging process.

Group Discussion and Lecture

Can We Change the Basic Behavior of Humans--Or Should We?

Human behavior, or the behavior of any living organism, is simply what that human or organism does. Behavior is accomplished primarily by muscle responses to actions of the nervous and hormonal systems of the body. The basic organization of these body systems is genetically determined or inherited and, to some extent, partly subject to modification by the environment. These changes take place at all stages of development, from the embryo to birth, through childhood and maturity, throughout the entire aging process.

About twenty years ago, evidence began rapidly accumulating in the areas of neurophysiology, behavioral genetics, comparative animal behavior, and other biological fields making it quite clear that much more of human behavior is inherited than we realized. Additionally, we are learning about ways in which our experiences can variously affect our developmental processes, so that inherited components and environmental components of our behavior have a mutual interdependence. We inherit a plan for the development of a very specific human being, but the details of this plan require specific environmental factors at just the right time, at all stages, from conception to adulthood for realization of the inherited plan, and environmental variation can to a degree, vary the end result.

Our behavior is probably influenced more by learning than that of any other creature, yet this in itself is an inherited capacity, with a biological (including evolutionary) basis.

In this short session, we cannot become experts on the biological basis of human behavior, but we can try to learn some new ways of looking at some old behaviors, and try better to understand the hereditary and environmental factors that might interact in an individual human to produce, or at least influence, behavior.

Studies indicate that even at birth, some personality traits differ between sexes, and as parents and family react to these differences, they tend to become reinforced. Most of the biological difference between males and females is the result of male hormore secretion during embryonic development in males, and lack of it in females. At puberty, both male and female hormones reach new, higher levels in the respective sexes, and the secondary sex changes we observe at this time include not only anatomical and physiological changes but psychologic ones as well, all of which are triggered by interplay between the nervous and hormonal systems.

In men, since testosterone seems responsible for their overall greater aggressiveness compared to women, we might suppose that varying levels of this hormone either at different times in the same individual or between different men could be correlated perhaps with aggression and violent behavior. As men and women age and the hormone level fluctuates, we might witness agressive behavior in females and docile behavior in males. Or, angry and violent behavior might be demonstrated by the increased suicide rate among older men.

The Evolution of Human Behavior

To describe human behavior without considering its adaptive value during human evolution would be to have no real understanding of the usefulness of the anatomical and physiological characters that have persisted in our species, since behavior and the organ systems producing it developed together in an inseparable manner. For example, humans are more motivated by sex drive than any other living beings. If

the function of sex drive were merely reproduction, we would not need such a complex set of behaviors and accompanying structural adaptations, and human sexuality is understandable only when functions other than procreation are considered.

When humans evolved from primate ancestors (a group of mannals including man, apes, and monkeys), they already had large brains, social cooperation, color-vision, semi-erect posture, and ability to manipulate objects with their front limbs. Most primates, however, also had (and still do) vegetarian habits, promiscuous mating, and no fixed "Home." The new, human technique of making a living that evolved, apparently depended upon cooperative hunting as a new type of food-getting, and this favored increased brain size, use of handheld tools or weapons, and increased social cooperation. Male hunting groups could not form if the typical primate sexual competition were present. But if males could form such strong ties with individual females that this "pair-bond" became recognized not only by the couple but by the group as well, then male hunting groups would feel free to leave. This pairing worked out with other benefits also. The large human brain must be small at birth, so humans are more helpless at birth and stay helpless a longer time than any other animal. The pair-bond would insure the female and young would receive their share of food (in other primates females must do all of their own food-gathering). No other primates form such strong pair-bonds, and their formation in early humans depended upon sex assuming such a powerful role that one mating pair could become bound with complex emotional and physiological ties.

Therefore, when sex in humans is viewed in this light, we can better understand why it is so powerful a motivator for behavior, including certain aspects of criminal behavior. Also, we realize that our preoccupation with sex is not "dirty," but a natural consequence of our biological heritage. The behavior of individuals classified as "dirty old men" may spring from this biological heritage.

Territoriality is another part of our biologic heritage. If an animal comes to regard a particular space or area as uniquely its own and reacts defensively against intruders of its own species into this space, this is a common type of territoriality. An animal's den or next, its feeding ground, breeding ground, and even the immediate space around its body are examples of types of areas that have special behavioral responses associated with them. In humans, territoriality is much more subtle, and usually not defended physically, but nevertheless, is a strong influence on human behavior. Our sense of personal space is also culturally influenced as well, and what seems too close a distance for conversation to one culture seems too distant for people in another, and these territorial factors can lead to unconscious reactions, as one party thinks the other is aggressive while the other feels he is being snubbed or given the cold shoulder. Many facial and body expressions seem to be instinctive cues to help define in an unspoken way these kinds of territories, while others are mainly learned. Add to this the normal aging process of sensory losses. Perhaps you need to stand close in order to hear--or to see--and others may feel you are intruding in their territory. Or, if you can't hear and pick up verbal cues, you might "jump in where angels fear to tread" and meet rebuff through rejections of facial and body expressions. The behavior of others and the aging individuals behavior can be greatly influenced by this evolutionary process.

While no single biological factor or combination of factors allows us to predict aging behavior, biology gives us clues. Man has an inherent capability of reacting and adapting to a degree unknown elsewhere in the animal kingdom. As we learn from experiments with mice and men, perhaps we can understand our own ageism, and create new living patterns to change the basic behavior of humans--or should we?

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SOCIAL GERONTOLOGY WORKSHOP
UNIT #3
PHYSICAL ASPECTS OF AGING

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 123, Benton Conference Center

CS 313B
Aging is ----- Normal

Resource Leader: Dr. Lois Rimmer, Associate Professor of Nursing,
Washburn University of Topeka

Session #10

Suggested Agenda

Introductory Lecture:	A New Way of Life: Normal Aging
Film:	Longevity: To Live to be 140
Lecture and Film Strip:	Physical Changes and Their Implications
Group Exercise:	What is your Reaction Time?

Feedback and Evaluation

Objectives

1. Present materials illustrating the physical changes that occur in the normal aging process.
2. Discuss the implications of the physical changes and how it affects social aging behavior.
3. Discuss the impact of ageism as individuals react to the aging process.
4. Present materials regarding common aging factors that occur in the normal aging process.
5. Increase the awareness of sensory losses and adaptations that may be necessary to cope with single and multiple losses in aging.

Introductory Lecture: A New Way of Life -- Normal Aging

It is difficult to separate our mind and our body as we view our own aging. "You're as young as you think you are." "He thinks old." We seem to think that aging is some kind of disease and that someday someone will find a pill or treatment and voila--forever young. Some try anything to "keep up that youthful appearance." Think of the Geritol ads that we see daily--will the husband really love his wife less if she is older--or looks older? Perhaps the trials and tribulations of Eileen Michael from an article in Best Years, a publication by the National Association of Mature Persons entitled, "A New Way of Life" might give us the lighter side of this normal aging process and how we fight it. . . .

> The day I turned 55, I hit the panic button. "Well, you blew it," I said to myself. "Here you are halfway through life and you'll never have time to do all the things you wanted to do. Face it. You don't look 55; you look 155. You'll never be young again."
>
> Fear? Disappointment? Despair? Whatever it was that gripped me, it finally drove me to do something to fight the spectre that haunts us all: old age. I decided to begin with my body.
>
> I joined a health club.
>
> "Oh, we can do a lot for you," the manager said as he looked me over.
>
> "But you have to stick with our program. You can't be a weekend warrior. You have to make exercise and good diet a part of your daily life. Why, if you keep fit, you can live to be 110 years old!
>
> "Besides, your appearance is your most valuable asset. Once we start on you, you'll learn to love exercising because it makes you feel great and look great, too."
>
> "How much will it cost?" I asked.
>
> "You can sign up for a three-month program for $130," the manager said. "Or you can have a one-year program for $35 a month plus a $30 enrollment fee. Think about it if you like, but I warn you, the longer you put it off, the harder it is to begin."
>
> It sounded so easy. Everyone there looked unbelievably fit in their black leotards and shirts. They did their exercise with zest and precision timing as rock music played in the background. I panted desperately on the thigh table and began gasping and wheezing while I attempted buttock V-raises on the Roman chair. After 45 minutes of pure agony, I staggered from the gym floor.

The experts were right. I didn't feel 55 anymore. I felt like I was 97 and yearned for a rocking chair. Could my fatigue be due to poor eating habits? Perhaps I should look into an organic diet.

Although my muscles screamed for rest, I walked to the nearest health food store, where the people looked even more fit than those at the health club.

"I think I'm eating the wrong things," I said to the owner.

"Can you help me with my diet?"

"Where do you buy your food?" he asked sternly.

"At the grocery store," I said.

"Well! No wonder you look so pale and tired. You aren't getting any nutrients,"

"Actually," he continued. "You can't get total nutrition in your food no matter how you try because of the way foods are processed and stored.

"Besides that, our vegetables are worthless because we are demineralizing the soil."

"No!" I gasped. I wasn't sure what he meant, but it sounded like a terrible thing to do.

"Where do you get organic vegetables and meats?" I asked.

"You have to grow your own," he said.

"I'll never have anything ready by dinnertime," I said. "Isn't there something I can buy?"

That was when he introduced me to the vitamin man.

"You don't know how good you can feel until you take our vitamins," he said. "I recommend 3 tablespoons of our protein powder and 12 all-purpose vitamins every day. I personally take 9 vitamin E tablets, too. I also take 6 vitamin C tablets. Why, if I get the flu, I can knock it out in three hours with a special herbal tea I brew of vitamin C and alfalfa."

"With all those pills, aren't you too full for meals?" I asked.

"We have special organic make-up, too. My brother sells that."

As if my magic, his brother appeared. "Did you know that the largest organ in your body is your skin?" asked the make-up man in greeting. "If you put garlic in your shoe, within minutes, it'll be on your breath!"

"I never thought of eating garlic that way," I said. "And what does that have to do with my make-up?"

He looked at me in disgust. "That's how fast your skin absorbs make-up, too," he said. "Did you know that commerical makeups have paraffin in them and preservatives? And your skin drinks it all up!

"We stress the same skin care for both men and women. We recommend that you cleanse your skin with oils from fruits and vegetables, grains and nuts. You should refresh the natural way. Our facials use cucumber, apricot and avocado creams. Our frosted lipsticks have special lustre because we use fish scales."

"Can't you taste the fish scales?" I asked.

My next stop was the beauty shop. If I was going to work on my body, my diet and my face, I really ought to do something about my hair. I made an appointment to see Walter, a successful beautician.

He took a long look at me. "Well, it's about time you came in here," he said. "You look terrible. Don't you realize the impression you make is very important in this youth-oriented world? We've been given 10 years longer to live, thanks to medical science. Why not take them at the corner of life instead of at the end?"

Perhaps if we separate our aging into certain aspects we can stand back and see it from a different perspective. To begin with aging is sequential. We start life at birth, either 9 months old, or newborn, depending on your perspective, and add a year to life every year. Ages start at 0 and continue throughout the numerical scales 1, 2, 3, 4, 5, 6, etc. Along the path we have set aside some of those numbers to conform to our primitive tribal need for ritual. At age 16 we can drive a car, at 18 we can drink alcoholic beverages, 21 used to be the age of maturity and 65 became the recognized age of retirement. But, as our civilization continues to accelerate, some young people are driving cars at age 12 and 13, and drinking a long time before they are 18--and ask any teenager and they will tell you, you don't have to be 21 to be mature anymore. And retirement, long debates about mandatory retirement and early retirement have filled the halls of Congress and caused business to take a second look at their retirement policies. About all we can agree upon with this issue is that aging is sequential for us all.

The second common denominator for us all is that age is cumulative. As we start from birth and continue on our life course, we add those years on top of others; the experiences, the illnesses, the accidents, the joys and sorrows. It has become a compliment to be told we "Don't look our age." If we have a flattering hair cut, we preen if we're told that we look ten years younger. I've read a lot of books about aging, but I've never run across any data that tells me what I'm suppose to look like at 20, at 30, at 60, etc. But, we all seem to carry around a measuring stick and can easily assign ages by personal appearances. Friends will express concern for an individual who has suffered emotional stress and "looks older." Does a thirty year old have 14 wrinkles and 6 grey hairs, and a

40 year old 46 wrinkles, etc. Some people have young genes and "hold their own" against physical aging appearances into advanced years. An article I read by Sula Benet as she visited the Soviet Republic of Abkhasia illustrates the dangers of this assumption,

> "I raised my glass of wine to toast a man who looked no more than 70. 'May you live as long as Moses' (120 years), I said. He was not pleased. He was 119."

He was hoping to accumulate a few more years to his cumulative total.

A third universal factor of human aging is that it is irreversible. We all travel through various life cycles, birth, adolescence, young maturity, maturity, old age. We start out as children, but we do not end our lives as children. We are old people. Granted, there are a few older people who have, because of the aging process, grown a little shorter. And, there may be a few behavior patterns that resemble the childlike behavior of an earlier age, but any professional who labels an older person a "little old man" or by the derogative label of a L.O.W. (little old woman) is demonstrating ageism of the first degree. By attaching the label little, we are taking away power and making the individual smaller and dependent upon us. Older individuals have lived the life of a child, so they know what happens there, but those that have not been old, do not know what that life cycle is from a personal perspective. Activity directors that find their source materials from primary books designed for children and make statements that the old people are "just like children" need a fast course in aging sensitivity. Limited motor flexibility may decrease the types of activities that older hands and limbs can accommodate, but the irreversible process of aging does not take away the years of living experience and the accumulation of knowledge and skill.

The final common denominator is that the aging process is normal. All organism age, some a little faster than others, true, but there seems to be a biological clock that ticks away and humans age--or have a life expectancy of about 75 years. One biological theory is called the "wear and tear" theory. It is based on a mechanical analogy that suggests that the body is like a machine and that eventually its parts wear out and the machine breaks down. This theory may seem logical, since we have so many organs performing highly specific functions in our bodies. And, in a limited sense, this theory proves true. For example, the valves of the heart perform a mechanical function, and some forms of heart disease result from calcification of these valves. However, it is difficult to show that any specific organ or system consistently goes bad or wears out in all older people.

This brings up another misconception about the aging process. We often view aging as a disease--something that can be cured and avoided. Disease does affect our aging process. The measles and mumps that we had as children were all computed into our bodies systems and traces of that trauma may spring up in heart disorders, or other organs malfunctioning. Also, the injuries that we have absorbed during our lifetimes may be highlighted in the aging process. The broken finger of our youth may

be the first joint to stiffen with arthritis, or the jarring fall that caused our back to hurt for a few days as a youth may become more and more painful. But, these are outside factors that we have acquired on our own. They are not written into our biological clock that ticks away in the normal aging process.

Fortunately a great deal of new information regarding health care and the biological process is becoming available each day. We realize that the knowledge that we have today is merely a base line upon which to build. Our interest in the aging process has increased greatly in recent years, along with the rate of increase in the numbers of people living into the later years.

Traditionally, the medical professions have been crises oriented, with the goals of cure rather than prevention. Recent emphasis on health maintenance throughout all life cycles has grown to include the later years. Studies show that older adults with poor health habits have higher mortality rates. If good health practices are established in the middle years, and carry over into the later years, the incidence and severity of illness are significantly reduced. The simple activities of daily living, such as diet, exercise, sleep, elimination, routine activities and adjustment to stress form a pattern which affects the degree of "wellness" so often overlooked and ignored in making plans for normal aging.

Developing good health habits is as vital to our aging as comprehensive financial planning is for retirement. It is important to be aware of some of the physical changes that may occur and be aware of ways to accomodate to such changes. We also need to remember that aging is a cultural phenomenon in our society as well as a biological process, with each facet having a significant impact upon the other. It is helpful for us to know which change in physical health is the result of the normal aging process, and which may be the result of environmental factors or personal living patterns.

As one ages, every major system in the body is altered. But, these alterations occur so gradually that most people intuitively make the necessary adaptations that enable them to maintain a high degree of independence. The human body is a beautiful machine, and if we work at keeping it tuned, we can expect a normal aging process full of pleasure and exciting experiences--a fit ending to a sequential, cumulative, irreversible and normal process.

Perhaps this excerpt from an editorial by Dr. William M. Eagles, President of Kiwanis International in 1973, eloquently expresses how the physical aging process and social gerontology interact on a humanitarian plane.

> "Oftentimes in the practice of medicine one encounters the aged, reaching out for help or support, sometimes just for encouragement. Whether in words or in demeanor, what these people are clearly asking us is that we give of ourselves--that we give physical support to the faltering step, moral support to the faltering ego.

As a doctor I have seen aging men and women at their most vulnerable. I have seen grave situations dramatically minimized by a physician willing to give of himself. I have seen illness and pain miraculously eased by the compassion of a nurse.

From a doctor's viewpoint, I must regard age objectively; aging, after all, is a process and not a disease, and so it calls for more than the skills and tools of the medical profession. The elderly suffer attacks on their integrity, the discomforting loss of their contemporaries, diminution of important social roles, and a lessening of trust, responsibilities, and dignity. There is a deadly agony in <u>being</u> when that being seems without reason. Man's greatest incentive to live is the conviction that he matters. Perhaps the best way we may give of ourselves to the aging is to help create opportunities for them to give of themselves."

Longevity: To Live to be 140

Since the beginning of recorded history, man has sought the key that would unlock the mystery of longevity.

Why are some people allowed to live decades beyond the rest of us? What are the secrets of those centenarians who live on beyond one hundred years of age with good health and human grace?

This film explores the unraveling of that mystery as the cameras travel to one of the economically poorest, most remote parts of Ecuador -- Vilcabamba, the home of some of the oldest living people in the world.

The centenarians of Vilcabamba offer varying reasons why they have lived to such a ripe old age. Ask a Vilcabamba woman who is 105, and she will tell you that it is "due to the climate and also to some flowers that give off a very healthy perfume." Ask a man who is 130 and he will tell you that he has lived so many years "because God willed it." Yet another might say that it is hard, physical labor and knowing that you are respected and wanted that does the trick.

There is a lack of emotional stress in the valley, as young and and old alike toil on the barren hills to raise scant food and survive. The Ecuadorian centenarians seem to share several common factors with the Russian Abkhazians. They both are never "retired," a status unknown in their language. From the beginning of life until the end, they do what they are capable of doing because they consider work vital to life. They eat little meat, for there is little meat. Only the vegetables and a few sheep, so perhaps it is the vegetarian diet. The climate is not humid and hot, so perhaps it is keeping the temperature cooled. Each person has a place in the societal structure, so perhaps it is the emotional support.

What are the answers to the mystery? Can our technological society share the same kind of extended good health? This film raises many questions regarding the complicated, interrelated factors of psychological, environmental, cultural and genetic that are the real ingredients of the "fountain of youth." The normal aging process takes place in Ecuador, in Russia, in New York and in Topeka. Many of the biological processes we all have in common. Why is the aging process timed differently in various parts of the world?

Film available from Documents Associates, Inc., 2116 Forty-Third Street, New York, New York 10017.

Traits indicate health

By BRIAN SULLIVAN

NEW YORK (AP) — Teen-age personality traits seem more important than early illnesses in predicting health in middle age, a University of California study has found.

"The calm and controlled teen-ager appears to have the best chance of enjoying health as a mature adult," says a report on the study at the Institute of Human Development at Berkeley.

That finding is based on studies of 66 men and 77 women whose personalities and health problems have been followed for more than 40 years. Middle-aged health also was matched with education, occupation and drinking and smoking habits.

"Persons with the best health when they were in their 40s and 50s tended to rate high in self-control and conformity to social conventions when they were teen-agers," says Marjorie Honzik, research psychologist.

As teen-agers, they were described as calm, even bland, over-controlled, dependable, likeable, satisfied with themselves, with a slow tempo, not easily irritated.

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Film Strip and Lecture

Physical Changes and Their Implications

Concept Media: Aging

Before viewing the film strip, discuss one or more of these "trigger questions."

1. What advice would you give a person who asked you how to retard the onset of facial wrinkles?

2. Name as many physical changes as you can that you have observed in the elderly. Which of these do you think are inevitable?

3. Is there a cure for aging?

4. What kind of prescription would you give for a long, healthy life?

The process of aging is a universal phenomenon characterized by degenerative and irreversible biological changes which seem to occur more rapidly after maturity is attained. These changes can easily be seen in a person's physical appearance: the loss or graying of hair, the wrinkles, the shortened stature. The functional ability is also affected, with the older person becoming slower, weaker and more easily fatigued.

The changes, both in appearance and in functional ability, do not all take place at the same time nor to the same degree in all individuals. For examples, while some at age 70 "look their age" and have had to adjust their lifestyle to a slower, more leisurely pace, others of the same age look and function as if they were years younger. While some are able to remain independent until they die, others live with severe restrictions and incapacitation in their final years. Both genetic and environmental factors determine the rate and severity of the inevitable changes.

In terms of heredity, it is known that related individuals tend to age in a similar manner and the closer the relationship, the more similar the aging pattern. In terms of environment, one's lifestyle seems to have a significant effect. For example, it appears that those who stay active physically and mentally tend to age at a slower rate than those who do not. In any case, most elderly enjoy relatively good health, many never having been hospitalized. In fact, the reality that they have lived to become old suggests that they have a certain biological superiority.

However, with advancing age, physical and physiological changes do make the elderly less able to withstand stress. They are more prone to accidents and more susceptible to disease. In addition, if they are injured or become ill, they will have a decreased ability to recover. An awareness of how age affects the major systems of the body forms the basis for understanding why the elderly function as they do, and how best to care for them when such care becomes necessary. With age, every major system in the body is altered, although many of these alterations have no known clinical significance. Some are known to affect everyday function, while others are significant mainly in the event of physiological stress.

The skin or integument:
The most obvious and readily observable sign of age, particularly the exposed skin. These changes give it a lined, wrinkled and dry appearance. All these changes generally present no functional problem, and the skin remains capable of protecting the body from bacterial invasion and from mechanical or chemical injury throughout life.

Muscoloskeletal system:
Diminished bone and muscle mass and varying degrees of joint stiffness and immobility. Osteoporosis, a diminishing of bone tissue resulting in porous bones and more liable to fracture is a trauma sometimes found in older people.

Nervous system:
It has been estimated that an individual begins losing several thousand neurons per day around the age of 25. This amounts to millions throughout the years; but as the brain continues to function in most as they age, it merely illustrates the tremendous compensating ability of the brain. Decreased blood flow to the brain can result in atherosclerosis, which can vary in severity from attacks of dizziness to a major stroke.

Special senses:
Vision - cataracts are common, also glaucoma. There can be difficulty in focusing on close objects as the lens losses its ability to accommodate. Corrective lenses, medication and surgery are available to correct failing visual acuity.

Hearing - gradual loss and a decline in the ability to hear certain frequencies. Impaired ability to communicate can be one of the most devastating aspects of advancing age and can often lead to social isolation.

Respiratory system:
The ability to take air into the lungs changes with skeletal and muscular changes. The lungs enlarge and become less elastic, resulting in decreased diffusion of air. Strenuous physical activity can cause a shortness of breath much sooner than when the person was younger.

Cardiovascular system:
The heart muscle shows little change in size with age, but it requires more time to recover from any trauma. Skipped heart beats become more common in older persons, and the heart rate may become a little slower. This limits the amount of oxygen going to the organs and tissues and may cause fatigue. Arterial inelasticity leads to an increase in systolic blood pressure.

Gastrointestinal system:
Although this system adequately carries out its functions of digestion, absorption and elimination throughout life, it is often the source of chronic distress. Heartburn, indigestion, constipation are some of the common chronic problems.

Urinary system:
There is a reduction in the function of the kidneys due to loss of nephrons, thus filtering about half the amount of blood per minute as when the person was younger. The ureters, bladder and urethra are also altered with age becoming less elastic and resulting in infections, frequent need to urinate and incontinency.

Each system in the body is affected by the process of aging. Generally, this process is one of atrophy--a diminution of cells and tissues, with a corresponding change in the structure and function of various organs. But, because persons initially have more cells and tissues than they need in order to survive, this loss of tissue can be thought of as reducing a tremendous reserve capacity--a reserve needed primarily when unusual circumstances arise, such as illness or emotional stress.

Therefore, with aging, it is inevitable that a person will be less effective in meeting the challenges of the environment. When a stressful situation arises, it will take the body longer to mobilize resources to meet that stress, and then longer before equilibrium is reestablished.

Some individuals will have significant age-related problems to which they will have difficulty adjusting, but most will hardly notice the slow decline in function to which they continually adjust. In the words of Simone de Beauvoir, "Old age is more apparent to others than to the subject himself. It is a new state of biological equilibrium, and if the aging individual adapts himself to it smoothly, he does not notice the change."

Snowbath is his 'waker-upper'

SHELLSBURG, Iowa — Warren Pangborn, 88, professes to be no great fan of winter — but says he doesn't believe in a lazy body.

So on winter mornings around sunrise, he strips naked and walks outside and for five minutes or so, rolls around in the snow.

He said he does it for "a waker-upper."

"I'm not a lover of cold weather. I've had to fight it just like everyone else.

"But I believe in putting stress on the body. A person should make his body work."

Pangborn said his heart is fine, blood pressure is normal and he's not bothered by the usual ailments that are common for people in their 80s.

"I get a great reaction from it. It makes you start breathing deep. It sort of gives me a feeling like I'm on top of the world.

"I don't shiver, but my feet get kind of cold. If it's nice soft snow, I like to lay in it. If it's not, I take the snow and rub it all over me until I am wet," he said.

Pangborn said his method is better than just getting in cold water because inside water only gets down to 32-degrees at its coldest.

"But when you do what I do, you get a lot more out of it," he said. "The temperature of the snow is down to about zero, so it does you a lot more good."

Pangborn said he keeps to his schedule except when its below zero and the wind is blowing.

"Oh, I don't think to go out if its much colder than 15 below and the wind is blowing. I don't like the wind very much," he said.

Calcified fetus carried 70 years

SWEETWATER, Texas (UPI) — A calcified fetus lodged in the abdomen of an 83-year-old woman for an estimated 70 years has been successfully removed for study by doctors.

A Sweetwater physician, who requested anonymity, said Tuesday a Colorado City, Texas, woman was vomiting and complained of abdominal pains when she arrived at his office May 23.

An X-ray of the woman's abdomen revealed the fetus, which was about four inches long and three months developed, he said.

An adopted son told the physician his mother had never menstruated and had never borne children. Although hospitalized five times, he said his mother apparently had never been X-rayed.

The fetus was removed during surgery the same day.

The doctor theorized the woman became pregnant at age 12 or 13 and that since she never miscarried, her body "assumed" she was pregnant, preventing ovulation for seven decades.

"We'll always wonder why the body didn't get rid of it," the doctor said.

mid-america
saturday
The Kansas City Times February 3, 1979

When They All Left Town, She Was Still Asleep

By Jean Becker
Mexico Ledger

STURGEON, Mo.—Alfred Hitchcock could not have designed a scene more eerie than the one that greeted 73-year-old Mrs. Lil Roberts when she emerged from her home here about noon Jan. 11.

Porch lights were on and garage doors stood open, but not a soul was stirring. The streets were deserted.

Sturgeon was a ghost town.

"I couldn't figure out where everyone had gone," Mrs. Roberts said. "And I couldn't figure out why everybody had their porch lights on."

Because her hearing aid had been turned off during the night, as it is every night, Mrs. Roberts was dozing when everybody else was leaving town. She had slept through the noise and excitement of a toxic chemical spill that forced the evacuation of the entire town—except her.

Friends and neighbors of Mrs. Roberts say they know someone knocked on her door and even tried to call her, but got no response. They assumed that she had already been evacuated.

But Mrs. Roberts had heard absolutely nothing. She woke up at 9 a.m., then decided to go back to sleep and stayed in bed until noon.

When she got up, Mrs. Roberts tried to call a few friends, but they weren't home. She then tried to call a repairman to fix her faulty stove, but no one answered the phone. So she decided to do a little shopping.

Before she left the house, though, Mrs. Roberts's son called from St. Louis. He had heard about the train derailment and chemical spill, and he wanted to be sure his mother was safe. So he asked.

"I thought that was odd," Mrs. Roberts recalled. She and her son finished the conversation without mentioning the spill, so Mrs. Roberts still didn't know where her neighbors had gone.

At first, Mrs. Roberts didn't realize that Sturgeon was empty. Nor did she notice the caustic smell in the air.

"I was never scared," she said, "but when there was no mail at the post office and no mailman, I knew something was going on. I also walked by the school, and there was even nobody there."

Mrs. Roberts walked all over town. A man at the hardware store told her to go home because the store was closed. But he didn't mention the evacuation.

Finally, a motorist stopped Mrs. Roberts and asked her what she was doing.

"I told him I thought I might be lost," Mrs. Roberts said. "The man told me to get in, and after I did, he explained what had happened."

Mrs. Roberts was taken to the First Christian Church in nearby Centralia, Mo., where most of her friends and neighbors were waiting for the evacuation to end.

The next day it did, and Sturgeon came back to life.

Group Exercise

Sensory losses do occur in the natural aging process. By experiencing the sensory loss, those working with the aged understand how the environment and professional interaction can assist, support and enhance coping and functioning by the older person.

What is Your "Reaction" Time?

1. Other Handness -
   - Pick up pencil or pen
   - Transfer to hand with which you usually do not write
   - Write for the next three - five minutes about thoughts and feelings about having to do this

2. Breath of Life -
   - Put a straw in your mouth and breath through the straw
   - Record your sensations after about five minutes

3. Auditory -
   - Put own hands or fingers over ears
   - Experience complete loss of sound as people talk
   - Reduced auditory input - distorted by holding one ear or the other

4. Sensory Touch -
   - Put masking tape on fingertips
   - Pick up pin from pin tray and pin two pieces of fabric together
   - Put on gloves - button sweater, tie scarf, tie tie or open a pill bottle

5. Mobility -
   - Bind joint (elbow-knee)
   - Walk or attempt to carry something with bound arm
   - Attempt to put on an apron tying it in back

   - Crutches - keep weight off of one foot entirely
   - Get up from seated position
   - Pick up two books or couple of balls or a cup of water and carry them from one location to another

6. Visual -
   - Tunnel vision
   - Hold the glass or bottle in front of one eye - close the other eye
   - Walk to a specified area on the other side of room (with the aid of a partner)
   - Discuss the sensation with your partner

7. Visual -
   - A trust walk - put cotton balls over eyes - bind on with scarf
   - One individual leads the other over a series of life experiences
   - Sitting down in a chair, going around tables, etc.

   - Yellow film over colored brochures - experience levels of visual acuity

8. Taste -
   - Hold your nose and taste Apple/onion/bread cube/cheese
   - Taste salt/sugar/put lemon drop on to tongue and retaste salt/sugar

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DOCTOR IS IN...
drawn for AMN
by Dave Harbaugh
...I'VE BEEN IN THAT EXAMINING ROOM AT THE END OF THE HALL ALL MORNING!... WHY HAVEN'T YOU COME IN TO SEE ME?!
...BECAUSE THAT'S THE LINEN CLOSET...

SOCIAL GERONTOLOGY WORKSHOP
UNIT #3
PHYSICAL ASPECTS OF AGING

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 124, Benton Conference Center

CS 313C
Drug Use and Abuse in Old Age

Resource Leader: Dr. C. Alton Barnhill, Staff Psychiatrist
Menninger Foundation, Topeka

SESSION #11

Suggested Agenda

Introductory Lecture:	Drug Pushing and the Older Consumer
Lecture:	The Drug Scene and the Elderly
Group Discussion:	Who is Responsible for Your Medicine?
Group Exercise:	What is Your Drug IQ?

Objectives

1. Present information concerning current advertisements and "drug pushing" aimed at the elderly.
2. Present materials concerning three types of elderly drug users 1)over the counter advocates 2)believer in miracle drugs 3)health food and vitamin faddist.
3. Present information regarding the changes that occur in the aging process in the body functions and how those changes effect the potency and life of the drug in an older body system.
4. Present materials for better health maintenance though education of drug use and abuse.
5. Present possible models for effective individualized drug record keeping and monitoring.

Introductory Lecture

Drug Pushing and the Older Consumer

So much has been written, spoken and dramatized about drug use and abuse by the youth in our society, that we have come to stereotype drug users as young people. There are many dramatic types of drug problems that are found among teenagers and young adults, such as the drug pushers in elementary and junior high schools, the school drop out who has become an addict, and the drug related criminal activities of youthful offenders. Numerous drug education and drug rehabilitation programs have been initiated to deal with the young person who has experienced some difficulty with drug abuse. But, there is a segment of our population that has not been the focus of this type of educational programming and concern that we may need to consider--namely, the older population. Let's examine some facts:

Fact - Medicare patients in hospitals receive an average of ten different drugs.

Fact - In 1965, 1/5 of all prescriptions were used by persons 65 years of age and older.

Fact - In 1977, this figure rose to 1/4 of all prescription drugs.

Fact - Persons over 65, representing 10% of the population, take 25% of all drugs prescribed.

Fact - Persons 65+ average 3.6 psychoactive prescription drugs such as Valium, Librium, Cope, Compose, Sleep-Eze, Sominex, Nytol.

Fact - 1/3 of all persons over 65 ingest 5 or more drugs simultaneously. Most commonly used are heart drugs, diuretics, tranquilizers and sedatives.

So, we find that older people are using or misusing drugs at a level which demands our attention and concern. The money and efforts which are expended for educational programs are certainly justified; but perhaps we need to broaden its scope and include education for and about drugs and our older population.

Magazine advertising, T.V. and radio commercials hold out attractive results to older people if they only use some kind of pill, liquid, ointment, health gadget, natural food, etc. We see an older couple on a fishing vacation having a wonderful time and looking beautiful and content. As they float by, the lady reaches down to the floor of the boat and holds up a bottle of laxative they are using. The intergenerational picture of the young woman learning from a parent the merits of Ex-Lax and, of course, the obvious good health of the users of Geritol are portrayed frequently. And the enviable amount of energy seen in the older person who takes his vitamins is sure to have some impact on the purchases made at the drug store. What about the older person who has trouble keeping dentures firmly in place or free of blueberry stains? There are as many answers as there are problems it seems, to the aging dilemma, if only one pays proper attention to the advertising in the mass media and ingests or applies externally the proper substance.

In addition to these over-the-counter (OTC) drugs, the number and variety of prescription drugs used by older people make it imperative that they have some knowledge about drug properties and possible consequences of combining drugs in an aging physical system. Education to learn what you are personally ingesting and how to insure maximum benefits from medications can be helpful all through the aging process. By taking some drugs, symptoms may be relieved for a short period of time without the disease being clearly defined. Examples of available literature include

these two books which might be a beginning step in exploring this concept: Bitter Pills by David Mason and Fran Dyllwer and How to Be Your Own Doctor by Keith W. Sehnert.

The interaction of drugs is rarely known and understood by many older people, of the health profession in general. There are three points to remember in this regard:

1. 70% of the drugs in use today were unknown and unavailable 15 years ago; therefore, there are no longevity studies available on these drugs to ascertain the cumulative effect in the aging process. It is an awesome task for physicians to keep abreast of these new drugs, particularly as they relate to geriatrics. Physicians have been offered very little emphasis in geriatrics in medical schools, with limited geratric courses being taught. Pharmacology books and courses do not deal with age related responses to drugs either. Special studies have been conducted concerning drug dosages for infants and young children, and you often see on a bottle special instruction for under six--but never for over 65.

2. There are certain changes that occur with the aging process that affect the action of drugs. Cell loss and changes in plasma components affect distribution. Changes in the gastro-intestinal tract affect the rate and degree of absorption of the drug. The biotransformation of drugs will be different with alteration of the aging liver, as well as changes in the kidneys and the elimination system.

3. Each individual will react differently, as each of us is unique and has his own peculiar allergies, metabolism, DNA/RNA, etc. These variances can be a slight degree or may cause completely opposite reactions in an older person. Some tranquilizers have been known to make the person more active.

Older consumers should be aware of some basic facts about drugs and be familiar with certain procedures in order to utilize the drugs effectively. As a start perhaps finding the answers to these questions would improve our drug education.

1. Prescription drugs: Do I know when, how and why to take it? What side effects might occur? Does the drug need to be refrigerated? Is it sensitive to light? May I take a drug that is prescribed for someone else with similar symtoms? How long may I keep the drug and safely use it again? Does it make any difference how many other drugs I am taking? How about using alcohol when taking this drug?

2. Over-the-counter drugs: Many of the same questions might be asked of the pharmacist. Older people often maintain their independence in every possible way, and this may take the form of making decisions about when and what medications are needed. Aspirin, Dristan, Alka-Seltzer, various sleeping compounds, laxatives and pain relievers often appear in the medicine cabinet, with little or no regard to the actual drug action or interaction with other drugs.

3. Vitamins: "One a day--or perhaps two or three? Do you know which particular vitamin is needed--A, B, C, E? Iron? Lessening strength and energy may seem like reason enough to try multiple vitamins. Checking with a physician before self medicating with massive doses of vitamin E, etc., may save the individual from serious complications which might appear in their health profile later and cause deterioration rather than restoration.

4. Health foods: The variety of such items to be found in the health food store is astounding! Wheat germ, seaweed, all kinds of grains, beans, dried fruits are available and made to seem highly desirable for curing all our aches and maladies. Folk medicine has for years offered proof that natural ingredients can act as laxatives, stimulants, astringents, etc. Individuals need to approach health foods with a realistic approach and carefully plan a diet that will include all the nutrients, vitamins, and bulk for their unique body and age.

5. Even the foods in the grocery stores may contain a surprising amount and number of ingredients which are not just "food"; i.e., preservatives. It is an interesting exercise to read the list of ingredients printed on a bread wrapper!

The elderly drug consumer needs to be aware of a few basic facts about the drugs they are taking. What does the drug do once it is inside the body? What is it expected to do for me? How does the aging process affect the action of the drug? What can I do to help the doctor and the drug? Our concern here is to encourage intelligent, effective use of drugs, rather than to deal with the addict. Drug addiction is not common among older persons unless they were addicted in earlier years, but many older individuals become dependent on certain medications because of lack of knowledge--theirs and the prescribers of the medications. A little education aimed at the older consumer and continued research on the effects of drugs in the aging process can certainly be a benefit to us all--for aging is universal to us all.

Unneeded Drugs Given to Elderly

By Kathleen Fisher
Star Medical Writer

A study of long-term patients at Truman Medical Center East has shown the institution was giving 175 elderly patients there the equivalent of $50,000 a year in drugs they didn't need.

Many patients were receiving expensive antibiotics for diseases from which they had recovered weeks earlier. In several cases, the study found, medical personnel administered a laxative and anti-diarrhea medicine the same day.

Others were in a "chemical straitjacket" from receiving routine doses of more than one tranquilizer, according to Dr. David Rush, doctor of pharmacy at Truman East.

Rush conducted the nine-month study to show the impact that supervision by a doctor of pharmacy could have on cost and efficiency in a long-term facility.

Beginning in December 1977 a team made up of Rush, attending unit physician Dr. William J. Beard, the nursing staff and the hospital pharmacist began keeping structured and closely monitored profiles of each patient's medication.

There are slightly more than a million long-term elderly patients throughout the country, health care and gerontology experts say. The nine-month Truman study dealt with 175 patients in the 210-bed unit.

Even before his study, Rush said, Truman Medical Center East probably was "better than most" about monitoring drugs patients received because the institution had a full-time in-house physician.

Although skilled nursing homes participating in Medicare and Medicaid programs must have their patients' medication programs reviewed monthly by a pharmacist, in many cases the reviewer is the same pharmacist who sells the institution drugs, the study says.

Of the $50,000 projected savings, $20,000 would have been paid by Medicaid. So few patients are able to pay their own bills, Rush said, that the tax-supported hospital could expect to write off most of the remainder as its loss.

The savings figure includes only that represented by the decreased cost of the drugs and dispensing them from the pharmacy. It does not include savings in such areas as nursing time for administering the drugs or medical care needed for overdoses.

After a four-month initial study, the team spent April studying each individual's file for excessive dosages and duplication of drug effects.

The number of units administered during the next four months, May through August, dropped 69 percent from the first four months for a sav-

See UNNEEDED on Page 5

Continued From Page 1

ings of $16,853, or more than $50,500 a year.

One woman's chart, for example, showed that she was receiving seven drugs routinely, two others frequently and several others less often.

Two of the routine drugs were tranquilizers. One was eliminated, the other reduced in dosage. The $50,000 does not reflect savings from dosages still being reduced at the end of the study, Rush said.

Excessive amounts of tranquilizers had to be withdrawn gradually, he explained. "Some people were just zonked. You can't stop them cold turkey, or even in four months."

Another drug being given to the same woman was one widely held to be ineffective in treating urinary tract infections. Another, being administered steadily, was a muscle relaxant intended for short-term use only.

Two others were laxatives, both of which were unnecessary when the patient was placed on a diet designed for her needs by the unit's dietician.

The cost of this patient's drugs decreased from $252.92 the first four months to $36.57 in the second such period.

Rush knows of only one study similar to his. The other study, conducted by a California doctor of pharmacy in 1975, only estimated drug-cost savings, Rush said, and placed heavier emphasis on hospital fees avoided by eliminating adverse drug reactions and overdoses.

Rush said that while 11 long-term patients became acutely ill during the first four months of the Truman study, only five had to be transferred during the last four months when drugs were decreased. That is an interesting but statistically insignificant difference, he said.

Many drugs for high blood pressure were replaced by a sodium-restricted diet. Medications often could be replaced with a less-costly brand of the same formula.

Some dramatic behavior changes occurred when drugs were withdrawn, Rush said. "We had some patients that weren't even talking. Once they got off chemicals, they got involved with people again. Others simply felt better about themselves."

Truman differs from some other facilities in employing physical, occupational and recreational therapists. In understaffed institutions, personnel feel pressured to tranquilize patients to keep them under control, Rush said.

Those same institutions could accomplish a lot if they plowed back into staffing the savings they would realize from not using so many drugs, he added.

Using a 1975 professional study to estimate at 3.22 minutes the time needed to administer one drug dose, Rush estimated that the new regimen saved the long-term unit nurses 6,277 hours the second four months.

Rush, who also serves as an assistant professor at the University of Missouri School of Medicine, said that although older patients almost always are given more medication than young people, they should receive less.

"They have more problems with side effects," he said. "Their liver and renal functions have decreased, so they have more difficulties with elimination."

Only two U.S. medical schools have geriatrics departments, he said, and the side effects that even conventional doses can produce in the elderly often are written off as senility.

Beard has been attending phyician for Truman East's long-term unit only about a year, although he was affiliated with the facility earlier through his position as assistant professor at the University of Missouri School of Medicine.

He and Rush are "of a single mind" in their commitment to reduced drug use and cost containment, he said. A team consisting of him, a social worker, a dietician, a nurse and either a pharmacist or doctor of pharmacy continues to make monthly rounds to talk with each patient at his or her bedside.

He expects cost savings to decrease even more as this approach is refined.

"Professionals in long-term care can't work in isolation," Beard said. "We're looking at the total individual, his setting, as well as why each treatment is being done."

Lecture

The Drug Scene and the Elderly

We live in a society today which tells us that we must not suffer! Whatever kind of pain we have, for whatever cause, we must find a way to eliminate or at least alleviate that pain. We also live in a society rich in technology, particularly in the field of medical research and new pharmacological discoveries. So, it follows quite naturally that if we are in pain, we must not be allowed to hurt, and thus there must be a pill to take!

Among older persons, this expectation of relief from the "miracle drugs" of the day often runs high and often results in serious medical problems and even death. With the incidence of certain diseases being higher among the elderly, and with the deterioration or loss of some of the usual support systems, they may turn to the use of drugs much more readily than they would have done in earlier years.

In earlier more active years, an individual might have looked to family members, close friends, or associates at work to listen--and sometimes this relieved the symptoms. Now, in later years, these people are no longer available (or have their own problems and are not interested); the children have left home and are too busy to be concerned; the church does not address itself to how you feel; community organizations seem to need your participation only when you are well; perhaps your long-time, familiar physician has died and you have to look for a new one. With the support systems gone, you look to the nursing home, mobile meal service, the local health agency, the senior center--all very helpful, but all very impersonal.

Now you begin to look for specific aids to reduce your pain and discomfort. Television commericals and magazine ads tell you how to make your dentures fit better, what to take for the ills you suffer from over-eating, and always the answer to insuring regularity of elimination! You have trouble sleeping? Dozens of different pills are on the market; so you not only have help, but you have a choice. Try several! Arthritis causes your knees to hurt and makes it difficult to walk? Don't worry--there are solutions to this problem, too, all done up in little bottles. From the dry skin on your face to the bunions on your feet, there is hope on the way. All you have to do is to get the product from the drug store into or on the part of your body that hurts.

For the person who wishes to be cautious about drugs, a visit to the physician seems the better part of valor. Even there, however, is the expectation that the doctor will prescribe a medication for each kind of malady which will stop the pain. With so many drugs available now, there seems to be something for everyone; and all too often the older person becomes a victim of our drug culture. For various reasons, he or she may be taking too much or too little, or a mix of too many different drugs, or one which produces bad side effects.

Enough information is available to know that there are age-related differences in the mechanism of drug action. Drug therapy in the elderly requires an understanding and incorporation of changing functional levels in absorption, detoxification, and excretion of drugs. Generally speaking, most drugs may be more active in older people even at reduced dosage levels. In view of the overall decrease of functional capacities, greater individual differences, and the drug interaction with particular organ systems, the choice and use of drugs for older persons is complex and should be made with regard for making the most of whatever potential and capacities that do remain.

Pharmaco-kinetics

Basic to the use of drugs, of course, is the knowledge of how they move through the body.

1. First of all, they have to be swallowed. It is surprising, but often a fact, that older people seek help for pain, have a prescription filled, and then do not take it. This may be the result of a kind of moral precept that forbids taking medicine; it may be fear of what will happen, skepticism, or even a matter of forgetting; but it may be important to be very sure that the patient has indeed swallowed the medication. To insure this first step, it will be helpful for the physician to explain clearly to the older patient what the medication is expected to do, exactly when and how it should be taken, how long before results might be apparent, and what side effects could possibly occur. On the latter point, it may be better to ask the patient to report to the doctor any unusual reactions, rather than to create anxiety about possible effects.

2. Absorption: This step is very important and will vary greatly with other bodily functions. The pharmaceutical companies calculate how fast the drug will be absorbed and give directions for its use, but other factors may keep it from being absorbed. The coating on a pill must disappear very shortly after it is swallowed. Too many different pills taken at the same time may prevent absorption of some.

3. Entering the blood stream is the next step, and in older persons the decrease in circulation will alter this process. The medication then goes through the liver which breaks down the compounds. In this step, there may be a build up of some of the compounds, especially in older people, causing the blood pressure to drop with serious results. Some of the compounds reach the kidneys and are eliminated from the body while others return to the blood stream and then to the receptor.

Drug interaction is very complex. Clinical pharmacists point out that every drug is toxic and should be considered as a poison. Each drug taken into the body has a certain metabolic path to follow. If several are taken at once and two or more are supposed to follow the same path, one has to get in line and wait. This waiting allows the dangerous build-up mentioned earlier, or may speed up enzyme induction.

Aspirin can cause severe bleeding because it interferes with the coagulating properties in the blood, or because left in an empty stomach too long, it will cause ulcerated areas and induce bleeding. The use of alcohol along with drugs can produce serious reuslts, both because of the alcohol content in some medicines and the interaction of alcohol with the drug. Smoking creates enzyme induction that speeds up the metabolism of most drugs. Fat soluble vitamins can be toxic as the result of being stored too long before absorption takes place.

Continuing Education programs for physicians in Kansas are now giving more attention to the reaction of drugs in the aging process, particularly the psychoactive drugs. Physicians need to be encouraged to stay abreast of the many new advances in geriatric pharmacotherapy through their professional journals and special courses at medical schools. If a physician fails to discuss the drugs he prescribes in terms of process, expectations, methods, side effects, etc., perhaps the patient can look to the clinical pharmacist for information and advice.

In summary then, we should remember that drug therapy will vary greatly from individual to individual, that drug interaction is very complex, and that older persons may react differently as the result of changes in body functions. With fewer functional units and decreased capacities of the many units that remain, absorption of drugs may be significantly reduced because of several factors: the number of intestinal absorbing cells may have decreased; altered gastric fluids may affect drug solubility; intestinal blood flow may be reduced; and transport mechanisms may not be as available because of faulty or reduced protein synthesis. Detoxification and excretion of drugs are frequently slower than in younger persons. Among the reasons for this could be a decrease in metabolism, increased circulation time, a decrease in blood flow and a decreased cardiac reserve.

In spite of the complexities and the dangers in using drugs, we need to emphasize the fact that older people can be treated and their illnesses can be relieved or cured by the use of pills, capsules and liquid medication. Drugs should not be used merely to pacify or tranquilize an older individual who may have a negative behavior pattern that could be altered by positive social interaction. Sometimes this type of "drugging" is done for the benefit of the caretakers rather than the individual, for it makes life easier to deal with a groggy, docile, old person rather than an alert, angry one. Drugs should be on the scene for the elderly. They can cure, relieve discomfort and increase vitality; but we must always search for more answers of how drug A reacts with drug B in the aging process and keep constantly updated on geriatric pharmacotherapy if we are going to be involved in the drug scene for older individuals.

Group Discussion

Who is Responsible for Your Medicine? You Are

Everyone, as they reach maturity, must take responsibility for their own individual health care. This includes proper exercise, diet and habits--and it also includes keeping track of your medications. The doctor, pharmacist, and health care professionals will not be the final judge of what and how often you take medication. The doctor may suggest that you take a medication three times a day, but you are the one who ultimately carries out this instruction. The pharmacist can put warnings on your prescription of potential dangers, but you are the one that must observe caution and avoid the dangers. In our complex drug culture, it is difficult to manage your own individual drug intake. To combat a fundamental lack of knowledge, perhaps this list of suggestions will be helpful in our personal management of drugs and medications.

WHEN YOU VISIT YOUR PHYSICIAN:

1. Tell him of your chronic or underlying disorders (such as high blood pressure, heart disease, diabetes, glaucoma).
2. Tell him what medications you take regularly (prescription and over-the counter).
3. If you find it helpful, before your visit, write down questions you want to ask during the visit.
4. If you are confused, ask for a further explanation.
5. If you are issued a prescription, ask if there are side effects.
6. If you feel it would be useful to you, have your doctor write down medication names, their purpose and how to take them.
7. Ask physician (and/or pharmacist) when you should expect to see therapeutic effects of a given medication.

WHEN YOU VISIT YOUR PHARMACIST:

1. Tell him of your underlying health disorders.
2. Tell him what other medications you are taking, and ask if interactions are possible.
3. Ask him how to take the medication (time of day, with or without food, with milk or water).
4. When purchasing over-the-counter medications, ask the pharmacist to check your patient profile and to recommend which medication would be the most appropriate.
5. Read the labels of over-the-counter medications.
6. Buy quality medications. Ask the pharmacist and your physician which medications are the best. Don't assume that all medications are the same simply because they bear the U.S.P. label.

WHEN YOU ARE AT HOME:

1. Be aware of how a medication makes you feel. Look for side effects.

2. Notify your physician of any untoward side effects or unusual changes you notice after taking a medication.

3. Keep your medications away from the bedside (except heart medications). Put them where you must go and get them. Be wide awake when you take them.

4. Make sure medications are kept in a safe spot so you and someone close know where they are, but others--especially children--don't.

5. Before you go to bed, get out medication for the following day.

6. Keep a chart of medication, listing its name, why you take it, and when you take it.

7. Do not attempt to do complicated or complex tasks under medication until you are sure how the medication affects you.

8. Don't mix medications, unless the pharmacist or your physician indicates that you may do so.

9. Remember, you are unique. Therefore, medicine may have a different effect on you than on others.

WHEN YOU CARRY MEDICATION WITH YOU:

1. Keep prescription medications in their original containers, with labels attached.

2. Do not put several medications in the same container.

3. Keep a card on your person with a list of illnesses, allergies and necessary medications.

Reprinted from the CHICAGO SUN TIMES, April 21, 1976

Group Discussion: Taking Medicine?

PERSONAL CHECK LIST FOR MEDICATION

1. Know the name of each of your medicines and why you are taking them.

2. Know exact directions for taking your medicines between meals...with food...swallowed whole...chewed

3. Know side effects of your medicine--some show it is working; others are danger signs to warn you to talk with your doctor

4. Know where to store your medicine--in the medicine cabinet... refrigerator...out of the light

5. Do not stretch your medicine by trying to make it last longer than it was prescribed for

6. Never borrow or lend medicine--only take your own

7. Ask for a complete label on all prescriptions and have it printed so you can read it--labels should include:

   Your name
   Your doctor's name
   Name of the drug
   Instructions for use
   Date prescription was filled
   Expiration date for drugs

8. Do not use medicine that is several years old--throw it out

9. Use a system to help you remember to take your medicine--a checklist or an association with a daily habit (hair-combing, plant watering, etc.)

10. Over-the-counter (non-prescription) drugs are for the relief of minor conditions--do not use these for prolonged periods unless advised by your physician.

Chart to keep close to medication - either inside door of medicine cabinet, on clipboard by bedside, in travel case or wherever medicine is stored.

Drug Name	Color/Shape	Prescribed For & By	Directions & Cautions	Time A Day	Need Refi
Persantine	small round hard orange coating BI/17	heart Dr. Harrison	take one tablet four times a day	7:30 a.m. 12:30 p.m. 6:30 p.m. 10:30 p.m.	last pil 6/10/78 need refi 6/8/78
Tetracycline	blue & yellow capsule Lederele	congestion & flu symptoms Dr. Ransom	take 2 capsules now, then 1 capsule four times a day until prescription is gone call Dr. if symptoms persist	8:00 a.m. 12:00 p.m. 6:00 p.m. 10:00 p.m.	take all of prescriptio no refil

Sample card to be carried in purse or wallet.
Made of heavy paper and folded in thirds and
inserted in plastic carrying case

NAME _____
ADDRESS _____
_____
TELEPHONE (____) _____
DATE FILLED OUT ___/___/_____
DOCTOR'S NAME _____
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BLOOD TYPE _____
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KNOWN DISEASES AND SPECIAL HEALTH PROBLEMS

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KNOWN ALLERGIES (MEDICAL OR OTHER)

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NAME AND DOSAGE OF MEDICATION BEING TAKEN (INCLUDING NON-PRESCRIPTION MEDICATIONS)

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IN AN EMERGENCY CALL:
NAME _____
ADDRESS _____
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TELEPHONE (____) _____

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Lecture

What Is Your Drug IQ?

Aging drug users become problem drug users when

1. They worship at the altar of medicine - "No matter what is wrong or how I feel, there is a pill or a bottle of something that will help."
2. They maintain a desire for independence to the extent of diagnosing their own ills and prescribing their own medications.
3. They listen to neighbors, relatives or the TV in determining what, when, and how to take drugs, or some new "natural cure."

Let's take a look at the typical contents of a medicine cabinet--yours, mine, his or hers. Put all the bottles, tubes, and boxes out on a table and see how much you know about each item. The typical medicine cabinet will yield aspirin (one or several types), one or more kinds of laxative, antacid, cold capsules and nasal sprays or drops, sleeping aids, various salves and ointments for the relief of abrasions, sunburn, insect bites, and muscle soreness, rubbing alcohol, camphor, mineral oil, iodine, mouthwash, merthiolate, medicated hand lotions, deodorant, cosmetics of all kinds for both men and women, and a number of items which could not be ingested such as cotton, adhesive strips and bandage. In addition, there are probably a number of bottles and boxes of prescription drugs. Some of these may be from one to ten years old, may not have clear explanations as to what they are supposed to do ("take one for pain" - for pain where?), and may represent two or more physician's who prescribed for the same symptom. How many different pills do you find which look very much alike - white, oblong, small? Placed in a small pill box for convenience in carrying in a purse or pocket, they could cause a serious problem.

Your drug IQ could be determined by how you view the contents of your medicine cabinet, and what you decide to do about it. A variety of helpful hints might help us use drugs effectively and not misuse and abuse our aging body.

The physical process of aging and the social forces in later life can collide and create stress and anxiety. Many older individuals do not use their stress symptoms - sleeplessness, upset stomach, etc. Value processing by older individuals did not usually include high regard for mental illness; so if a pill can be prescribed, you must be physically ill and that is O.K. Continued education for all about mental health in later years can do wonders in relieving drug problems in old age.

Learn to cooperate with your physician:

a. Keep a written record of your symptoms and any reaction to medication to refresh your memory when you visit the doctor's office.
b. Keep a written list of <u>all</u> medications being presently taken.
c. Ask about any new prescription: What is it supposed to do? How often do I take it? When do I take it (before or after meals)? Are there side effects?
d. Put your drug information on a chart for use at home.
e. Fill out a "portable" chart to carry with you that includes all your current drugs. Take card with you to doctor's office and fill in new drugs while there, either with his help, the nurses, or the pharmacist.
f. Keep track of your personal habits and the side effects and report them to your doctor. Were you nauseated? Did you take it on a full or empty stomach? Did you feel dizzy? Had you had any liquor while taking the drug?

Work with your pharmacist:

a. Ask for easy-to-open bottles (not childproof).
b. If physician did not give complete information and instructions about the drug, ask the pharmacist.
c. If buying over-the-counter drugs, ask how they might interact with prescriptions.
d. Do not expect the pharmacist to give you prescription drugs without a physician's prescription.

Organize a system for taking your medicines:

a. Develop a chart to list name of drug, purpose, color and shape, times for taking, other directions and cautions.
b. Use a color code system. Place a bright color line or check on the bottle to match the color used on the chart.
c. Use some kind of container such as a small muffin tin or egg carton for the daily or weekly supply of pills (if this method is used, be extremely careful to keep it out of the reach of children or pets).
d. Be sure to avoid exchange of similar looking pills.
e. Commercial pill carriers are presently available that allow you to dole out your daily or weekly doses. As you look in the Monday slot and find a pill, you know you haven't taken your Monday pill; or if you're to take four a day and two are there, you've only taken two.

Lobby for the development of a pill dispenser that would help older people to keep track of medications taken.

As drug consumers, we don't need to all enroll in a basic course in pharmachology. It really isn't essential that we know what a bound and a free drug is or about biotransformation and drug absorption. But, we should raise our drug IQ to be aware of our own personal drug consumption and personally monitor our own "drug habits."

DRUGS AND THE AGING

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"I felt a lot better after taking my medicine for a couple of days so I decided to save the rest."
When you stop taking your medicine too soon whether you're feeling better or not you're risking your health and sometimes even your life.
The same can be said for increasing your medicine on your own or for doubling the dose to catch up when you find you've forgotten a dose.
Make sure you ask your doctor how long you should continue taking your medicine as well as how much and how often. and then follow his orders.
Do it-yourself medicine can get you into trouble.
"And I'm old enough to know better."
ME
Medicines that matter from people who care
ROCHE

SOCIAL GERONTOLOGY WORKSHOP
UNIT #3
PHYSICAL ASPECTS OF AGING

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 123, Benton Conference Center

CS 313D
The Ecology of Aging

Resource Leader: Dr. Frederick H. Rohles, Jr.
Institute for Environmental Research
Kansas State University, Manhattan, Kansas

SESSION #12

Suggested Agenda

Introductory Lecture:	The Ecology of Aging
Lecture:	The Place of the Elderly in the Man-Environmental System
Group Exercise:	Creating our Personal Environment
Group Discussion:	Thoughtful Use of our Environment Benefits us All

Feedback and Evaluation

Objectives

1. Present materials relating the demographic, societal structure, physical aging process and the physical surrounding to the ecology of aging.
2. Present materials about the ecosystem complex and how it relates to older individuals.
3. Increase awareness of the need for adaptation of our immediate environment to meet our individual needs.
4. Discuss the various perspectives of older individuals residing in an adult care home and the administrator running the adult care home regarding the use of personal space.
5. Discuss societal and individual adaptations to enhance our physical environment.
6. Discuss various architectural designs that best respond to aging needs

Introductory Lecture

The Ecology of Aging

Exploring the world of the relationships between older people and their environments, we are transcending the science fiction world and entering into the frontier of the ecology of aging. The major impact of gerontology ecology is made up of the sum totals of at least four individual factors; demography, societal structure, the physical aging process and the physical environment.

Statisticians are recording both the increasing numbers and the increasing percentages of older people in the world population. The "moving bubble" of the baby boom of the 1950's is already impacting on our environment with once crowded elementary schools now closing because of reduced enrollment. Our family roles and individual roles are in a constant state of change within a societal structure that is in an evolutionary process. The family role of mother and grandmother are not exact models of fifty years ago- and will alter more in the next fifty years. Exploring our own individual status in this changing societal environment is a lifelong process. Our physical aging process affects our environmental view. A baby crawling across the shag carpet has an altogether different perspective than his mother running the sweeper over the same carpet. The physical abilities, biological processes and relationships with that part of our physical surrounding all interact with where we are in the aging process.

We tend to emphasize the physical over the social environment in our construct of what ecology is. Physical environment is important, but we must not forget the social environment, especially for older individuals, may become equally vital. Great surgery can be practiced in a tent - or a sub-level physical environment, but having the proper setting and support systems enhances the experience for the patient. Likewise, having the proper kind of social support after the surgery improves the chances for survival.

The social environments' importance might be compared to an "interest question." One bank offers 5% interest on your savings, another 20%. Which would you choose? You're receiving something from both, but the extra 15% might be vital for survival, particularly for older people.

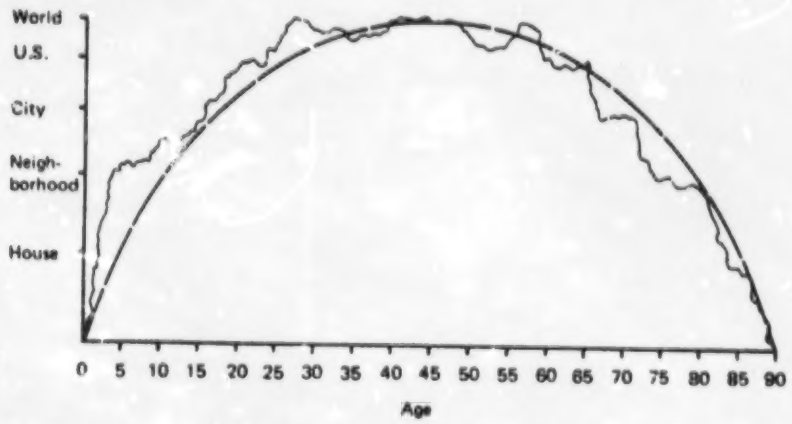
Having a little reserve "saved for a rainy day" might help combat depression and loneliness as losses and changes occur in the normal aging process. In the societal structure, one finds that life long friends are getting older. Some may die or become physically disabled, thus taking away many opportunities for social interaction. Communities and neighborhoods are in a state of transition in varied environmental settings. The house next door may be torn down and a new elderly high rise built there. Or, you may move from a small rural setting into that urban elderly high rise. The environment also begins to include more age stratification, or loss of intergenerational roles. You no longer can freely move from the "young married Sunday school class" to the "busy couple group," but are classified as the "old timers discussion group."

A physical environment fact indicates that only between 5% to 7% of the 65+ population live in an institutional setting at any one time. But, the majority of the population of adult care homes are 65+ -- and people 80 and over are more

apt to need the supportive care of an institutional setting. Various changes in physical environment are now available to an older individual that fall between the upkeep and complete maintenance of a private home and the dependency of the supportive care of a nursing home. Because of the various role changes and losses and changes in physical mobility, the move from the family home may go through several stages in our aging process.

As the children grow up and leave home, the multi-bedroom home may become a chore to maintain and heat, etc. Perhaps buying a smaller home or condominium would make your immediate environment more enjoyable. Incomes are often reduced by retirement and the taxes and maintenance of a home may be impractical. Perhaps renting a smaller apartment or duplex would meet your changed economic status. The aging process can cause some physical slowdowns, and mowing the lawn and shoveling snow may become a chore. Maybe moving to a warmer climate and settling in a retirement village would be best. The death of a spouse sometimes causes the survivor to move. Perhaps the companionship of a residential hotel or retirement community would create a balance in your ecology of aging.

As we look at the long-range planning for our physical environment, perhaps we should keep in mind that life space changes with age. As this chart indicates, we are more content to be homebound as we grow older, with our journies out into the world becoming closer and closer to home.



Life space change with age. Life space in this context is defined as the individual's ability to access differing plateaus of spatial use. This is a schematic diagram that represents the life-space characteristics of an imaginary individual and is not meant to represent any particular person or group of persons.

"Neighborhood Planning for the Urban Elderly," Victor Regnier, Aging, Scientific Perspectives and Social Issues, *Birren and Woodruff, eds.*

But the physical environment is but one part of the ecology of aging. The societal impact adds to the picture and as comprehensive planning is done by more and more older individuals for living alternatives in later years, perhaps these questions should be included as dialogues take place.

Do you want to live formally or informally? Do you want to own your own home, rent an apartment or live in a hotel or retirement complex? What is your preference for residing at or near the seashore, or the mountains, or other scenic attractions? How about roaming the United States in a recreational vehicle? Do you want to live near relatives, a son or daughter? Do you enjoy

cultural events and would there be a variety offered in your new setting? Are there potential companions in your peer group and others with whom you might establish primary and secondary relationships? If you desired, could you make contributions to community progress? Do you enjoy gardening, hobbies and craft activities that require special space and facilities?

No one but you--that unique aging individual--will be able to respond to these and other environmental questions to design your ecosystem. Keep in mind that "a man's home is his castle" whether it is a lean-to on a tropical isle or a fortified castle on a mountain top. Being aware of the choices that respond to the ecology of aging can make our later years even more fulfilling.

"Those Sunday dinners at Nanny and Poppy's house will always be good memories for all of us."

"My family is my whole life and that's why family reunions are important to me."

Lecture

The Place of the Elderly in the Man - Environment System

Environment: The total of circumstances surrounding an organism or group of organisms; specifically, the combination of external or extrinsic physical conditions that affect and influence the growth and development of organisms.

Ecology: The science of the relationships between organisms and their environments.

Ecosystem: An ecological community together with its physical environment considered as a unit. (Eco(logy) + system.)

Ecology, environment, ecosystems, words seldom used in everyday conversation ten years ago, but today all age groups are aware of their concept. Individuals are becoming increasirgly concerned about man's place in this ecosystem complex. We are aware that the environment has a significant impact on the quality of our daily lives - and on our overall aging process. Our physical and social environments are in a state of constant change, and sometimes complicate the adaptations that we are trying to make because of our biological aging process.

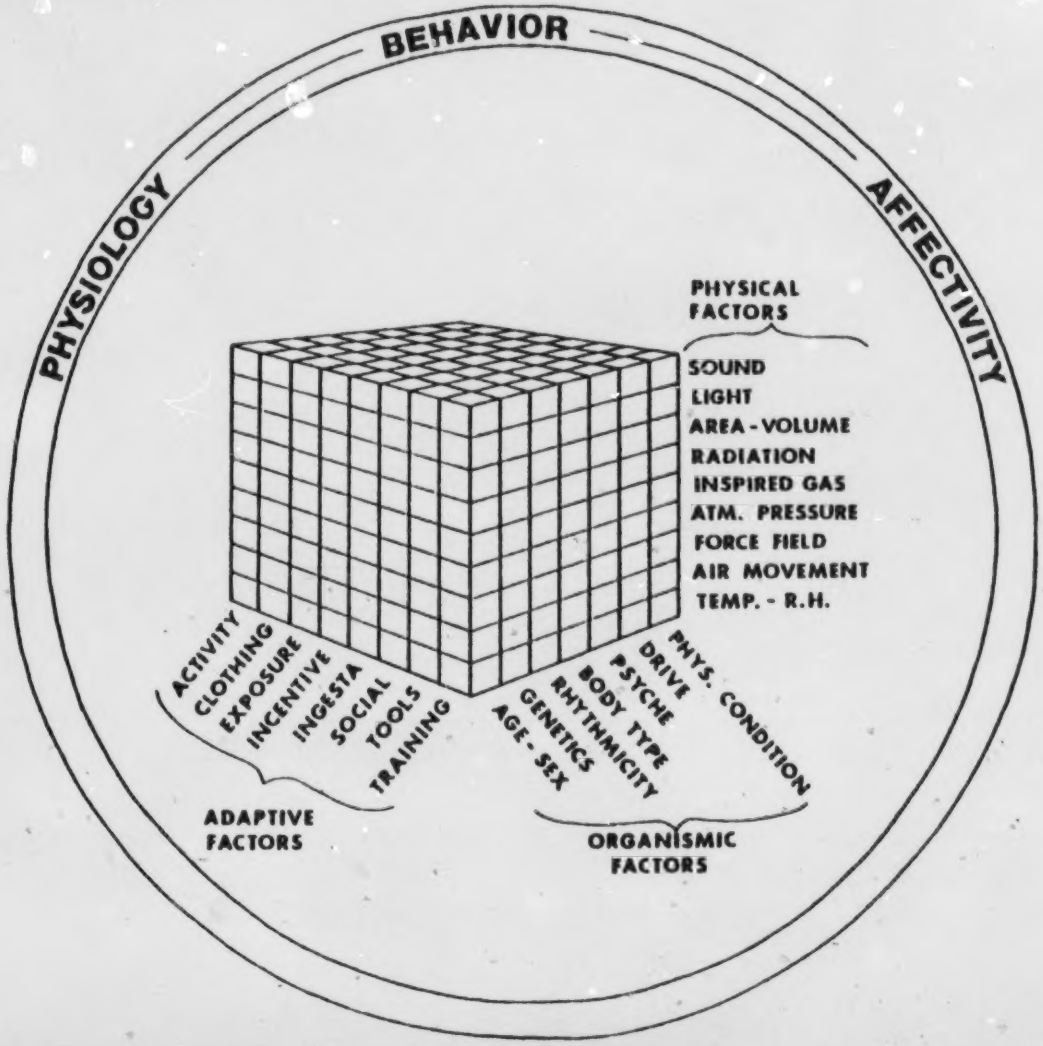
As we gain knowledge about our environment, and the complex interplay of the air we breathe and the social stress that causes us to breathe that air in rapid gulps - we learn that we can, through comprehensive planning, exercise some control over the nature and changes in our environment. Understanding the relationship of the aging process and the behavior of older individuals in coping with environmental factors is crucial in order to respond to the present generation of old people - and to plan for all future generations of old people.

THE ECOSYSTEM COMPLEX, prepared by Dr. Frederick H. Rohles, Jr., Institute for Environmental Research, Kansas State University, Manhattan, Kansas

THE ECOSYSTEM COMPLEX

THREE DIMENSIONAL REPRESENTATION OF THE VARIABLES THAT MUST BE DEFINED WHEN EXAMINING THE EFFECTS OF THE ENVIRONMENT OF PHYSIOLOGY, BEHAVIOR AND AFFECTIVITY.

Prepared by Dr. Frederick H. Rohles, Jr.,
Institute for Environmental Research,
Kansas State University, Manhattan, Kansas



To illustrate this multidimensional, complex ecosystem let's visualize a cube containing many squares, each square being a variable. We'll label the three major variables 1) physical factors, 2) organismic factors, and 3) adaptive factors.

1. Physical factors (it's all around us)

   A. Sound - the noise level may be too loud and cluttered - or may be a "deafening" silence. Each can affect an older person's sleeping pattern, social interaction, fear level, and emotional stability.

   B. Light - this includes candlepower, daylight or artificial light, glare, color, view of natural light for the normal day-night cycle.

   C. Area - the territorial space, enough to feel you can move about freely, but not to big to "defend".

   D. Radiation - heat and glare from the windows, hot drafts of air and small particles from artificial sources.

   E. Inspired gas - odors, what if your room is over the vent for the kitchen and you breathe onion and grease fumes all day?

   F. Atmospheric pressure - hospital emergency rooms expect more patients in low pressure periods. Some people are very weather sensitive and both health and emotions are affected by high and low atmospheric pressure.

   G. Force field - is it a "normal" or "exotic" surrounding?

   H. Air movement - what is the ratio of outdoor air to indoor air, what are the number of changes of air in an hour?

   I. Temperature and relative humidity - as we age our body's thermostat doesn't work like it did when we were younger.

2. Organismic Factors (What's inside us)

   A. General physical condition - 40 pounds overweight? exercise daily? chronic illness?

   B. Rhythms - biorhythms may affect our heart, respiration and temperature.

   C. Body type - Examples include two types that are labeled the screener and the non-screener. The screener is very selective and focuses on specifics. The non-screener needs novelty and complexity to catch their attention for they are affected by all stimuli.

D. Drive)
)
E. Psyche) Varies with each individual and affects
) reaction and relationship to the environ-
F. Genetics) ment.
)
G. Age - sex)

3. Adaptive Factors

A. Activity - if there is nothing to look forward to, why even bother to get out of bed - or out of the house.

B. Clothing - comfort may become more important than style - the backless/toeless high heeled shoes may give way to "sensible shoes".

C. Exposure - 24 hours a day in one environment can be pretty dull, if the environment never changes you might be pretty dull.

D. Incentive - does anyone care - do I care enough about myself - how's my self-esteem working today?

E. Ingesta - the kinds of food and drink we put in our bodies - also drugs, pesticides, chemicals, etc.

F. Social - the size and composition of the group - do you have common interests, rapport?

G. Tools - what do you have to work with - do you have the proper "tools" to adapt to the changes such as eye glasses, hearing aid?

H. Training - if you can no longer see to read a recipe, can someone train you to cope in another way - perhaps by oral instructions?

Physiology, behavior and affectivity interact upon the aging process within this ecosystem complex.

The immediate living arrangement is one of the most important ecological settings for older individuals. The type and quality of the housing is related to available income, health status, type of community (urban/rural), family status and perhaps membership in a minority population group. Demographic data illustrates certain trends in living arrangements among the elderly that help to put housing into perspective. For example, 70% of the people over 65 own their own homes, even though the income level might be lower than average. Maintenance costs, property taxes and utility bills can be immediate and major problems. Residential concentrations of older people are predominantly in inner cities and small rural towns. The variations in the availability of supportive services in these environments will have varying impact on aging individuals in those ecosystem complexes.

There is a growing trend for developing congregate housing designed for independent living. The other two types of housing most common among older people are single family homes and health related institutions. Faced with various difficulties in maintaining the former, and reluctant to accept the latter, the older person seems to favor the apartment which purports to be designed especially for the elderly. Many of these housing projects, however, have completely ignored the principles of environment as described above and show violations of most of the principles of good human engineering. Someone has said, "The only difference between a bad architect and a felon is that the architect never returns to the scene of his crime."

The criteria for design of living space which the older person might follow in considering any type of housing are:

1. Performance - are you able to use the apparatus safely, easily, effectively?

2. Affectivity - how do you feel about the facility - do you really like or dislike it?

3. Independence - can you live here and function day by day without the help of others?

4. Preference - among this and other designs of facilities, which do you prefer?

In good housing, there will be signs of individuality in each room. Even very small things can be important links to the past, and individual possessions play an important part in establishing identity and the self esteem of the individual in later life. Personal histories are connected with physical structures and geographic spaces. Re-establishing a new neighborhood or area or relationships may be perceived as more difficult as the aging process takes place. We sometimes see this dramatized, as in this recent news article describing the tragedy of an older woman freezing to death in the home that she had known and loved. The final quote of "She was very upset when she learned she would have to move to the apartment. There's just a certain feeling that some of us have -- that she went back home because she couldn't adjust to the new neighborhood," illustrates this need for positive self identity established within our personal life space.

In contrast, one also finds delightful incidents about "there's no place like home" and a differnt type of living arrangement associated with an older woman. Little did the property owners suspect as they arranged for this woman to live rent free that she would, a) live to be 100 and, b) the rising cost of property values and maintenance of property would impact upon their agreement. Changes are taking place daily in all our ecosystem. We need to take note of the changes and include them in our planning. Being aware of the immediate ecosystem of older individuals now and in the future can only enhance life for all individuals -- ourselves included.

Woman freezes in home she loved

LOUISVILLE, Ky. (AP) — Housing officials moved Margaret Lewis to a comfortable apartment fearing she would freeze to death in her dilapidated home.

But the 75-year-old woman died of exposure — back in the vacant house where the doors and windows had been broken out by vandals.

She was curled up on a bed of newspapers, and friends and relatives said memories had brought her home.

Her funeral was Thursday.

The body was found last Friday, curled up as if asleep for the night on newspapers on the floor of the living room.

Junk left by vandals was scattered about. A picture of her late husband, Garrett Lewis, was found close by, along with a family Bible on the mantel and two family pictures on the wall.

Medical officials had to wait until Tuesday to perform an autopsy because the body was frozen.

Jefferson County Deputy Coroner Robert Carter said the autopsy showed that Mrs. Lewis died of exposure and it was impossible to tell how long she had been dead.

She was dressed for bed, and her other clothes were not recovered, but police officer John Hass said foul play has been ruled out.

Sister Cathy Bohler, a social worker for the state Department of Human Resources who helped her get medicine and groceries, had been unable to find Mrs. Lewis at her apartment just before Christmas, and neighbors said they hadn't seen her for several weeks.

The city's housing inspection office got Mrs. Lewis to move Dec. 1 by ordering her house vacated. A city relocation officer, Sister Clarellen McGinley, found her an apartment 15 blocks away and said she seemed pleased with it.

But two of Mrs. Lewis' nieces, who live in Lexington, said the move upset her.

One, Joyce Jones, said Mrs. Lewis had lived in the old neighborhood, in a house just across the alley from her recent home, "for a long, long time, and her two husbands had died while she was living there." Mrs. Lewis moved across the alley when the house where she had lived most of her married life was torn down a few years ago.

"She was very upset when she learned she would have to move (to the apartment)," Mrs. Jones said. "There's just a certain feeling that some of us have — that she went back home because she couldn't adjust to a new neighborhood."

EDNA SNOWDEN. . .legal 'squatter'

Woman lives 50 years in house without cost

By CHARLES HILLINGER
L.A. Times-Washington Post Service

SUNSET BEACH, Calif. — For 50 years Edna Snowden has lived in a house that doesn't belong to her, and where she pays no rent, utilities charges or upkeep.

In all that time the house has had eight owners, none of whom has been able to evict her or take full possession of his property.

"It's because I've lived so long," explained Miss Snowden, 101, who has lived in the residence since 1928.

She moved there as a live-in housekeeper and companion to Mrs. Mary Jane McKinley, whose husband died in the 1920s.

When Mrs. McKinley died in 1946, her two sons inserted a clause in the deed for the Sunset Beach property which declared that the house was Miss Snowden's to live in rent-free until she died. Miss Snowden was 68 at the time.

The clause also specified that the owners of the house were to maintain all the utilities and provide whatever work was necessary to keep the place livable at no cost to Miss Snowden.

"If those boys knew I'd live to be more than 100, I don't think they would ever have changed that deed the way they did," Miss Snowden said.

Miss Snowden outlived Mrs. McKinley's two sons. When they died, their share in the house went to their widows. One of Mrs. McKinley's daughters-in-law presented her share to a missionary society. The other share was passed along to Mrs. McKinley's granddaughter, Debbie Hudson.

Mrs. Hudson later bought the missionary society's interest in the home and held the deed for many years. When she moved to Arkansas two years ago, she sold the house to a schoolteacher.

The house, across the road from the beach, is valued at more than $90,000. Sunset Beach is 27 miles southeast of Los Angeles.

Miss Snowden lived alone until five years ago when Maria Mercado, now 61, moved in with her as a housekeeper and companion.

Group Exercise

Creating Our Personal Environment

Procedure: In the first column rank by number the items you would move with you to a shared 15' x 30' room in an institution. In the second column rank the items as an adult care home administrator admitting the resident. Discuss the similarities and the differences.

	ITEM	COLUMN I	COLUMN II
1.	Bookshelves / 2 large boxes of books		
2.	Pet (cat or dog)		
3.	Color TV		
4.	5 small plants & 2 large floor plants		
5.	10 framed family pictures		
6.	Private phone & listing in local directory		
7.	"Lounge" chair for TV watching		
8.	Crystal lamps		
9.	Stereo & box of records		
10.	"Gold" rimmed goblets - antiques handed down by great-grandmother		
11.	Scrapbooks of vacation memorabilia		
12.	Card table & 4 chairs		
13.	Wooden occasional table made by grandfather		
14.	3 handmade needlepoint pictures		
15.	10 professional & honorary framed awards		
16.	14 assorted bric-a-brac given by grandchildren in last 10 years		
17.	Sewing machine		
18.	Cedar chest		
19.	12 handpieced quilts		
20.	Electric food processor/blender		
21.	Large basket of "crafts" yarn, etc.		
22.	Suitcase full of family pictures		
24.	Walnut breakfront		
25.	12 place-setting of Haviland china		

Group Discussion

Thoughtful Use of Our Environment

We need certain elements in our environment as we age -- basic survival, security, opportunities for socialization, meaningful activities and at least one satisfying primary relationship. In adapting to the environment for changes that occur in aging, sometimes we don't even respond to the lowest level of Maslow's hierarchy -- that of security and safety. Using past experience and common sense, let's design a safe, secure environment that might be appealing to us as we grow older and experience changes in physical mobility and number of primary relationships.

General living area

Entrance:
1. Doors that operate easily
2. If multi-stories, elevator that operates easily and safely
3. Adequate lighting at night
4. Secure doors and windows for privacy and safety
5. Entrance and halls wide enough for wheelchair
6.

Windows:
1. Easily opened and shut
2. Low enough that an individual seated in a chair can look out at the view at eye level
3. Secure with locks and screens
4.

Private living area

1. Telephone within reach of bed and from floor
2. Thermostats accessible from wheelchair
3. Chairs, divan, etc., designed for firm support and comfort and ease of standing up from sitting position
4. Clear pathways between bed and bathroom
5. Electrical extension cords safely out of pathways
6.

Kitchen

Stove:
1. Control panels on back can cause burns as you reach over them
2. Control panels on front can be accidently activated
3. Oven at eye level reduces need to bend and lift

Refrigerator:
1. Small efficiency boxes put under counter are difficult to bend and utilize -- kneeling on floor to look in back of bottom shelf difficult for anyone.
2. Frost free advantage for keeping sanitary and clean.

Counter space:
1. In small areas, pull out shelf helpful in meal preparation
2. Sliding shelves and lazy Susans in corner cabinets
3. Electrical outlets at mid level rather than floor level
4. Lighting over work area rather than center of room
5. Proper height for wheelchair? standing? kitchen stool?
6.

Misc. features:

1. Skid proof stool
2. Secure, comfortable chairs for meals, snacks, socialization
3.

Bathroom

Shower:

1. Built-in corner seat
2. Skid proof strips on floor
3. Hand rails
4. Faucets with push levers rather than turn handles
5. Soap on a rope
6.

Bathtub:

1. Hand rails on wall and tub side
2. Skid proof strips on tub floor.
3. If congregate housing, call button that can be reached from floor or in tub

General:

1. Privacy for dressing and undressing
2. Skid proof scatter rugs
3.

Other features

1. Area for interaction with others -- front porch, comfortable lobby or lounge
2. Seating areas for conversation, rather than lined up chairs
3.

These features are intended to be used as seed lists -- let's work together and think through other special needs and considerations that might make the environment more pleasant for our aging changes. So far the list deals with physical conditions and adaptations--perhaps we need to sprinkle in a few plans that respond to social and personal enrichment needs or all levels of Maslow's hierarchy that can make our aging ecosystem ideally suited for the later years.

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Cultural Values and Aging

Washburn University Gerontology Institute

SOCIAL GERONTOLOGY WORKSHOP
UNIT #4
CULTURAL VALUES AND THEIR IMPACT ON OLDER KANSANS

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 124, Benton Conference Center
Tuesday, April 10, 1979

CS 314B
The Immigrants

Resource Leaders: Esther Wolf, Family Health Service
Kansas City, Kansas
Vivian Umbarger, Social Gerontology Coordinator,
Washburn University
Jeanne C. Tucker, Director, Gerontology Institute,
Washburn University

Suggested Agenda

Illustrated lecture:	Remembrances of our heritage in wood, brick and stone
Lecture:	What have ethnohistorians discovered about aging?
Lecture:	Como se llama? How do we find and serve the foreign born Kansan?
Lecture and group discussion:	What value is ethnocentric aging?

Objectives of session #13

1. Discuss the similarities among various ethnic groups to explore universal concerns and resources.
2. Present materials explaining the immigration patterns of the early 1900's and how they affect the aging demographic profile.
3. Increase awareness of the wide diversity among persons of Spanish surnames.
4. Present information explaining unique cultural experiences that impact upon older American immigrants.
5. Increase awareness of the language barriers experienced by foreign born older persons.
6. Discuss the value processing of older foreign born Americans as they perceive the value of age.
7. Recognize similarities among various ethnic groups to explore universal concerns and resources concerning gerontology.

Objectives of session #13 (Continued)

8. Recognize ethnic differences of value processing in order to enhance an understanding of real needs and resources inherent in the group.

9. Become aware of the uniqueness of personality types in all aging ethnic groups as behavior patterns.

10. Begin to separate anecdotal tales from established documented data concerning ethnic differences and similarities.

Introductory Lecture

Remembrances of Our Heritage in Wood, Brick and Stone

We are a nation of immigrants. But, perhaps in order to increase our awareness of the impact of this statement we should define the who's, where's and why's.

The Who's - they left a home and came to America

Emigration - the departure of a person from their native land

Emigrant - one who emigrates or leaves their native country

Immigrate - to enter or settle in a country to which one is not a native

Immigrants - one who leaves a country to settle permanently in another

And there were many who came to America in the 19th century - statistics show us some peak years for immigration of specific ethnic groups.

1860 - 4 million Irish
1881 - 4 million English
1882 - 1 million Swedish
1890 - 6 million Germans
1910 - 3 million Russians

Where? The map indicates large settlements in specific states, but practical knowledge and official census indicate diverse ethnic populations in all states.

Why? A Nation of Immigrants by John F. Kennedy

"The forces that moved our forebears to their great decision to leave their homes and begin an adventure filled with incalculable uncertainty, risk and hardship - must have been of overpowering proportions."

Religious oppression, political unrest, droughts and famines were the dramatic forces that brought about these decisions - and the construction of our country refects the imprint of these waves of immigrants that settled in Topeka.

Shawnee County is blessed with a rich architectural heritage and lasting visual affirmation of the diversity of the immigrants that settled here. Thousands of barns, houses, churches and stores reflecting the immigrant's heritage are scattered across the countryside. These buildings have stood through the turmoil of "Bleeding Kansas" dust storms and world wars and now share a common history. But, as we study some examples from Remembrances in Wood, Brick and Stone. A Historic Preservation Project by the Topeka-Shawnee County Metropolitan Planning Commission in 1974, perhaps the diversity and characteristics of the Shawnee County immigrant can be visualized.

A NATION OF IMMIGRANTS
ALASKA
HAWAII
CHINESE JAPANESE
WASHINGTON
JAPANESE NORWEGIANS SWEDISH FINNISH
OREGON
JAPANESE NORWEGIANS SWEDISH FINNISH
SPANISH
IDAHO
ENGLISH SWISS
MONTANA
YUGOSLAVS
WYOMING
SCOTS ENGLISH
NORTH DAKOTA
RUSSIANS NORWEGIANS GERMANS SWEDISH
SOUTH DAKOTA
DANISH DUTCH GERMAN
NEBRASKA
CZECHOS-OVAKS GERMANS
KANSAS
GERMANS
COLORADO
GERMANS SPANISH
NEVADA
IRISH FRENCH SWISS
UTAH
SWISS ENGLISH DANISH SCOTS SWEDISH DUTCH
CALI-FORNIA
RUSSIANS SWISS ITALIANS FRENCH JAPANESE
ARMENIANS CHINESE MEXICANS SPANISH
ARIZONA
MEXICANS SPANISH
NEW MEXICO
SPANISH MEXICANS
OKLAHOMA
TEXAS
SPANISH FRENCH MEXICANS
MINNESOTA
NORWEGIANS FINNISH SWEDISH DUTCH
WISCONSIN
SWISS GERMANS IRISH
MICHIGAN
RUMANIANS BELGIANS SYRIANS POLISH
IOWA
DANISH DUTCH
ILLINOIS
RUSSIANS POLISH HUNGARIANS RUMANIANS SWEDISH
MISSOURI
GERMANS HUNGARIANS
INDIANA
OHIO
HUNGARIANS RUMANIANS CZECHOS-O-VAKS GERMANS
KENTUCKY
FRENCH SWISS
TENNESSEE
ENGLISH
ARKANSAS
ENGLISH GERMANS
MISSIS-SIPPI
ENGLISH
ALABAMA
ENGLISH
GEORGIA
ENGLISH
LOUISIANA
FRENCH
FLORIDA
SPANISH
CUBANS
S. CAROLINA
FRENCH
N. CAROLINA
ENGLISH
VIRGINIA
W. VIRGINIA
ENGLISH
PENN.
MD.
NEW YORK
MAINE
ENGLISH CANADIANS ITALIANS PORTUGUESE
FRENCH
IRISH
ITALIANS ENGLISH
ITALIANS FRENCH
POLISH ENGLISH
ITALIANS POLISH SWEDISH
RUSSIANS BELGIANS
CONN.
RI
Atlantic Ocean
Gulf of Mexico
PUERTO RICO

220

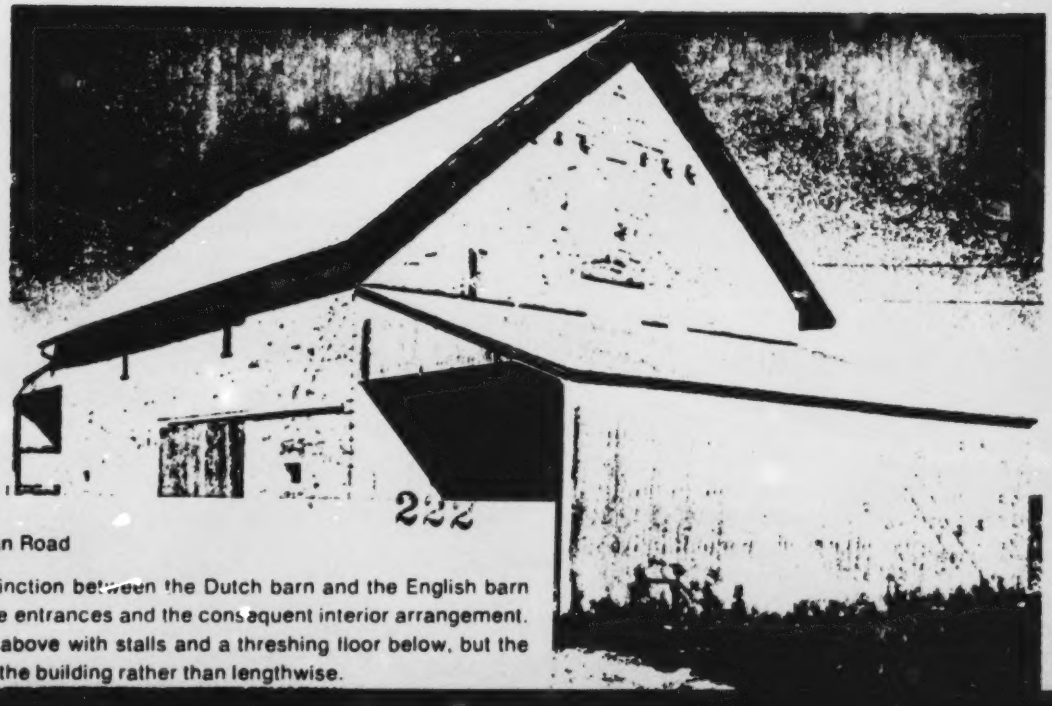
221

The farms of Shawnee County reflect the impact of the immigrants.

DUTCH BARN
NW Forty-Sixth Street and Huxman Road

One of the oldest types of barn to be found in North America, the Dutch barn was brought into New York State by immigrants from Germany and Holland during the seventeenth and early eighteenth centuries. It is ideally suited for agricultural functions with its easily accessible storage areas, its side aisles for cattle stalls, and its large central threshing floor.

This beautiful example in stone was built in 1868 according to local tradition.



ENGLISH BARN
1649 NW Huxman Road

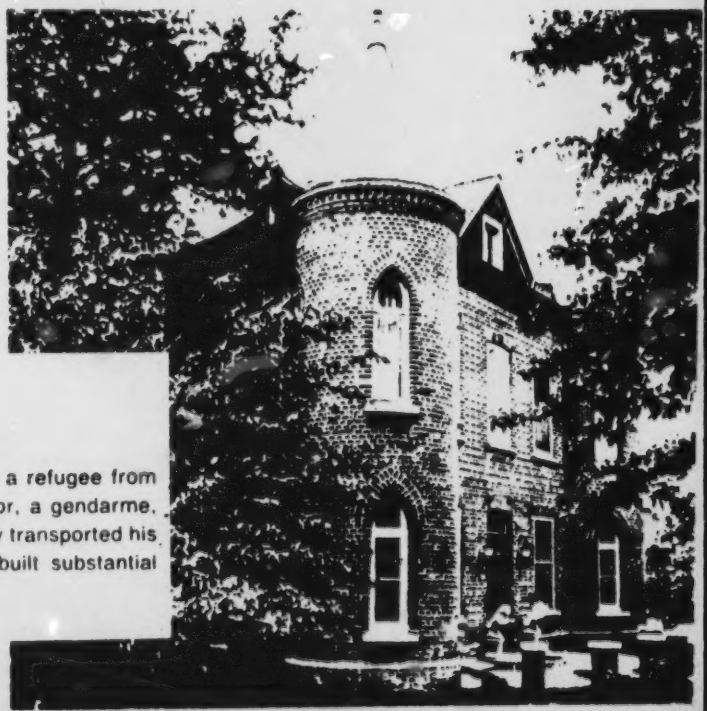
The primary distinction between the Dutch barn and the English barn is the latter's side entrances and the consequent interior arrangement. It, too, has lofts above with stalls and a threshing floor below, but the axis runs across the building rather than lengthwise.

Be it ever so humble - a man's home is his castle - and mirrors his past.

WORTH HOUSE
SW Fifty-seventh Street, Dover

Immigrants from northern New England, primarily Vermont and New Hampshire, are said to have settled in Dover Township in the 1860's. This is supported by the Worth House which, with its salt-box shape, is strongly reminiscent of New England dwellings.

In Northern Dover Township was one of the earliest communities in Shawnee County. Uniontown was established in 1848 by Government agents to the re-settled Pottawatomie Indians. Situated on the south bank of the Kansas River, the town served as a supply post for thousands of travelers headed west to the gold fields. At the height of its prosperity in 1850, Uniontown contained some forty log buildings, but an epidemic of cholera shortly afterward led to the abandonment of the site by 1853.



MATROT CASTLE
6424 Huntoon, Topeka

The Castle was built in 1883 by Seraphin P. Matrot, a refugee from political turmoil in France. Successively a contractor, a gendarme, and a winemaker in Paris, Monsieur Matrot apparently transported his love of wine across the Atlantic for he reportedly built substantial cellars under his new home.

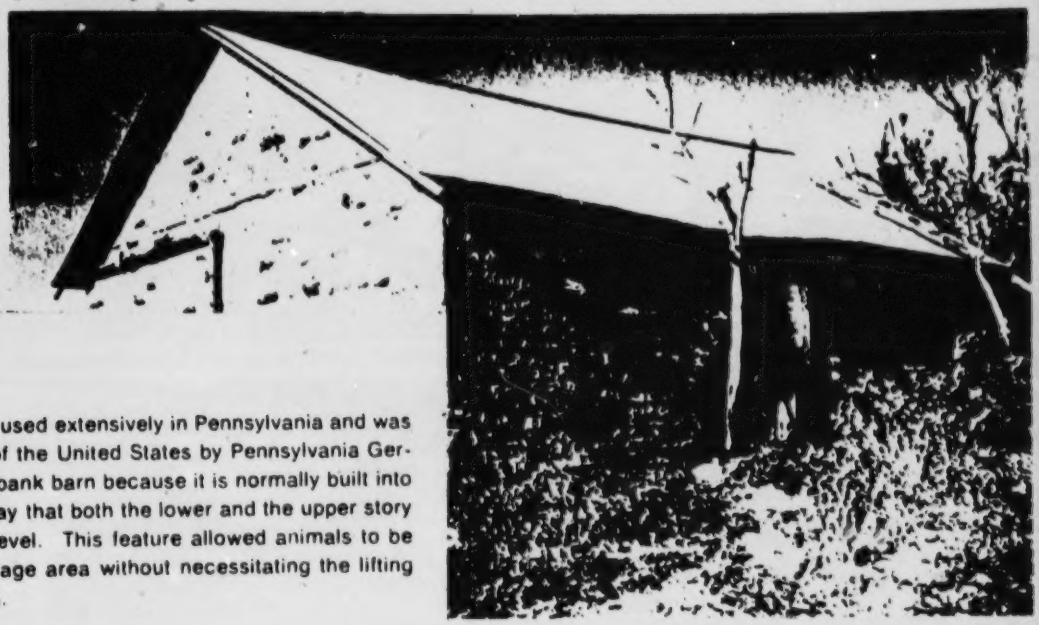
Communities of immigrants within the county, such as Tennessee Town, Little Russia emerged throughout Topeka.

RESIDENCE
207 Hancock Street, Topeka

Thousands of German-Russians left their homes on the Volga River for Kansas in the late 1870's, just as over a hundred years before they had migrated from Germany to Russia. Conditions had become intolerable in recent years so they were more than receptive when agents for the railroads, particularly the Santa Fe, told them of the free and prosperous life to be found in Kansas. Most of these immigrants found their way to Topeka where many decided to stay while others went westward to settle on the prairie.

Those who stayed found ready employment in the many rapidly expanding local industries, of which the Santa Fe railroad was the most important. Naturally enough the German-Russians settled near their work, forming tightly-knit little communities such as that just east and south of the Santa Fe yards and "Little Russia" in North Topeka. Although there are few physical remains of these communities, they apparently had a strongly European flavor. Contemporary reports speak of the peculiar heavy clothing, the lusty singing, and the brightly painted buildings of this cultural element. The flood of 1903 destroyed most of the physical aspects of the community, and even though there were efforts to reestablish it in its old form there was never again the same cohesiveness.

Be it a German bank barn - or a German bank, the various waves of immigrants affected the Topeka economy in many ways.



GERMAN BANK BARN
3023 NW Glick Road

The German bank barn was used extensively in Pennsylvania and was transported to other areas of the United States by Pennsylvania German settlers. It is called a bank barn because it is normally built into a bank of earth in such a way that both the lower and the upper story can be entered at ground level. This feature allowed animals to be stabled underneath the storage area without necessitating the lifting of materials up into that area.

GERMAN-AMERICAN BANK
435 South Kansas Avenue, Topeka

225

Built on the site of the earlier Kansas National Bank, the present structure was erected in 1910 C. D. Cuthbert, a prominent architect, had his office there.

The melting pot - as one community of immigrants geographically integrated, the physical structures accommodated more immigrants.

MEXICAN BAPTIST CHURCH
231 Hancock Street, Topeka

In January of 1882, this church was first occupied by the Third Presbyterian Congregation, which maintained possession for approximately ten years. By 1896 the building had become a center for the German population as St. Paul's Evangelical Church. Slowly, however, the ethnic composition of the area changed from predominantly German to predominantly Mexican. Consequently, in 1924, in an effort to meet the religious needs of the new community, Dr. Edwin Brown organized a Baptist mission known as the Mexican Baptist Church.

This building is one of the most handsome in Shawnee County. It retains a strong northern European flavor from the time of its occupation by the Germans, which gives it a unique charm.

Lecture

What Have Ethnohistorians Discovered About Aging?

Since 1820, when the United States government began to keep immigration records, more than forty million immigrants from some forty countries have arrived on our shores to make their homes. Many of these people settled in the Middle West, and without them, our story would be vastly different.

We need to look at our heritage and the ethnic differences of the people who have lived and grown old in order to really assess their strengths as well as their needs. It is imperative that we have at least some degree of understanding of these ethnic differences before we try to assess needs and plan services.

Ethnicity is part of everyone's identity; it refers to race, religion or national origin -- from the Greek word "ethos" meaning people or nation. Ethnicity does not mean the same as a minority. A minority is a group that is ethnically different and less in number than the dominant population.

Ethnic identity is of a historical nature. One is born into an ethnic group and becomes socialized, learning its history, its hardships and accomplishments, its value system.

Factors Affecting Minority Aging in Our Society

1. Each minority has a special history in relation to the American social system. Each group arrived in the United States in different circumstances. Some came as slaves, some were here already and were conquered; still others came as cheap labor to be exploited, as political refugees, or seeking religious freedom. The common denominator for all is their minority status and therefore subordination to the dominant ethnic population.

2. Because of the differences in language, appearance, and customs they had different work roles from the majority, and as a result there arose stereotypes above each group in relation to achievement which fostered further discrimination.

3. Each of these groups belongs to a subculture that involves its own unique values and/or language differences. The alienation from their own heritage and isolation from the dominant social institutions led minorities to develop their own coping mechanisms such as the church, strong family ties, folk tales or songs, or a society or club.

4. The experience of the young generation of minority groups is different from that of their elders, and this creates a gap within the group between generations in understanding the experiences of each other. As a result, the aged are sometimes isolated even within their own minority groups.

5. There is often a higher rate of poverty among minority groups, and a higher rate of poverty among the aged of minority groups as a result of discrimination. However, we must remember that neither aging nor minority in and of themselves is an index of poverty.

The focus of our concern should be those elderly in the minority groups who cannot advocate for themselves because of language differences, lack of education, or feelings of fear.

A cultural value is a widely held belief that a characteristic of the culture is "good" or "bad," "right" or "wrong." People of a given culture may value privacy, certain material possessions, nudity, certain animals, work, physical strength, etc. Values reflect which activities, relationships, feelings, or goals are important in a society. Values form our definition of self, and of the nature of reality.

Value systems vary from culture to culture -- and from one ethnic group to another. These value systems affect every aspect of the culture, including the social expectations of the aged -- and the aged person's self-perception. Some cultures foster views of old age which are conducive to happy, contented later years. Other cultures maintain views which lead to feelings of worthlessness, despondency, and futility.

Cultures vary in the extent to which they emphasize individualistic achievements and self-reliance. "A cultural value system which incorporates the individual into the group and provides security for all persons may raise the status of the aged. Some societies stress the work role and encourage striving within a competitive economy. In such a society, the older person tends soooner or later to lose out in the struggle and to be pushed aside." (Cowgill, Donald and Holmes, Lowell. Aging and Modernization, New York. Appleton-Century-Crofts 1972)

Cultures also vary in the way they define old age. In some societies, age is defined in functional terms -- being able to perform certain physical functions. In others, old age is defined in formal terms, dependent upon some external symbolic event (the birth of a first grandchild, or a certain birthday, for example). If a culture values work or chronological age above self-esteem and social status for the aged, that culture can be described as "ageist."

Lecture

Como se llama -- or How do you call yourself?

What's in a name? We seem to label the world around us to cope with the multiple stimuli--and sometimes create stereotypes and confused terminology. Let's examine one minority group and the diversity of labels that have been attached in an attempt to classify and categorize.

1. Spanish surname. The census counts the names that "sound" Spanish. There can be many "hidden" and "lost" in this count if the name is Anglo like Wolf, Jones, etc.

2. Spanish speaking. How do you clearly identify the bilingual--might there be some confusion about gifted Spanish language students?

3. Spanish origin. Anyone who can trace their ancestry back to Spain--all of us might have some problems tracing our ancestry back four or five generations.

4. Mexicano--a person born in Mexico.

5. Mexican-American--caught between two cultures--born in America of Mexican parents.

6. Latinos--from Central America.

7. Cubans/Puerto Ricans--from Cuba and Puerto Rico.

8. Chicano--used by young people, not accepted by older people.

9. Hispanic--this label is widely accepted today to define all the above--but do we know what it means?

And if we have trouble with the simple task of a commonly communicated identification--visualize the complexity of the problem if English is not your predominate language. How do you reach the people that need services and because of language difficulties are not receiving them? In most ethnic groups, even a person from the same ethnic group is considered an outsider if they are not of "that community." But there are formal and informal techniques that a dedicated outreach worker can use.

Formal methods include the linkages with the aging network. The information and referral services of the Area Agencies on Aging should have a staff person who speaks the language, or close contact with a bilingual service provider. Close coordination with these Spanish speaking resources should be maintained to maximize communication. SRS, Social Security office, Legal Aid Societies should have Spanish speaking staff personnel to help with financial, immigration and social problems. Community Development Agencies have data that pinpoints clusters of ethnic groups in city blocks. Knowing where the target population actually lives can be helpful in outreach efforts. Specific Spanish speaking service agencies such as LULAC and El Centro can be a coordinator of information and services.

Informal techniques include the use of the media--radio, TV and the newspaper. Special newsletters in the native language can sometimes carry information to the target group. Informal visits to an ethnic neighborhood to explain a service or new program on a personal, face to face, relationship may be even more effective than a written communique. Churches are important contact points, for the older members of the ethnic group are probably still faithful members. Most Catholic churches keep constant census counts of their parishes and an updated assessment of needs. Organizations such as Knights of Columbus, Legion of Mary, G.I. Forum are also possible contact points for the outreach worker to visually see what is happening and begin the informal salesmanship of programs. Neighborhood grocery stores are a vital link. Food is tied to the family life and if a small grocery store is in the neighborhood, the information exchanged here still has the flavor of the "old country store." One visit will not be adequate to correctly assess needs and relay information. Broken promises from social agencies and misunderstood information have created a wait and see attitude. Information gathered can be utilized for future planning and the visit will be establishing trust and credibility.

Once the contact has been made, there are several subtle ground rules that the outreach worker should be aware of as an interview takes place. Cultural values of a bilingual person usually dictate that the interchange be courteous and respectful. To say no is considered rude, so the approved response is yes even if the question is not understood. If the interviewed individual is not bilingual and the conversation is not in their native language, the interviewer might not be aware of idioms and subtle differences of language if the language is a learned and not native one to them. Carefully check out responses, for mis-communication can occur when both speak English and the complications of translations sometimes cloud the issues even more. Cultural guidelines also prescribe subtle questions--not the direct inquiry about personal parts of the body or intimate family details. This type of information is not exchanged between young/old, men/women normally and the interviewer should be sensitive to this hesitation. A leisurely pace at the first meeting will be more likely to build a foundation for future interaction. Brusque, rushed questioning is not a cultural inheritance and will cause tension and anxiety on the part of both the interviewer and the interviewee. Inquiring about the children, general health and small courtesies are all part of accepted custom as interactions take place.

Supplementing the verbal questions with written information adds to the clarity of information exchange. If it is a serious problem, the individual may want to confer with other family members, and having a written document acts as a reminder of vital points. The widow is <u>expected</u> to confer with the eldest son or a brother--it is not indecisiveness on her part, but a part of conforming to their culture.

Awareness of the limitations of a translator also need to be made clear. Certain age related "respect for elders" may affect the accuracy of the exchange. Family roles dictate that a younger son does not ask his mother questions about her body or personal social problems. If the translator is the same sex and age the interaction may be more accurate. One example of this type of misfired communication of different ages/sex was a son acting as an interpreter for his mother. The symptoms that she described were nausea and dizziness, and he translated them into morning

sickness. She was given a medication to counteract the morning sickness. Actually, she had an inner ear infection that was discovered when the medication did not alter her condition. In the complexities of modern medicine, it is difficult enough for two people who speak the same language to communicate, let alone the complications of translation and diverse cultural values.

These diverse cultural values are illustrated in this passage from a paper written by Nathan Murillo, Assistant Professor of Counseling and Psychology, San Fernando Valley State College entitled The Mexican American Family.

"Let us now examine one cultural difference as an example: attitudes toward material things. In the Anglo society values stemming from the Puritan view tend to emphasize work as a form of responsibility leading for the most part to rewards of a tangible nature. The Anglo world is described sometimes as divided into two categories: those of work and those of play. The responsible individual is the one who works first so that he can later enjoy his recreation with or among his material gains. However, a vicious cycle may be formed because recreation often then becomes an obligation for the purpose of enabling the individual to go back and work more effectively and with greater energy than before. The Mexican American is likely to have a different orientation. To him material objects are usually necessity things and not ends in themselves. In contrast to the Puritan ethic, work is viewed as a necessity for survival but not as a value in itself. Much higher value is assigned to other life activities in the Mexican culture. It is through physical and mental well-being and through an ability to experience, in response to environment, emotional feelings and to express these to one another and share them that one experiences the greatest rewards and satisfactions in life. By comparison, any pursuit of material things by the Mexican American through work and the accumulation of wealth are likely to suffer. To the Mexican American it is much more valuable to experience things directly through intellectual awareness and through emotional experiences rather than indirectly through past accomplishments and accumulation of wealth. For the Mexican American, social status and prestige are more likely to derive from an ability to experience things in this kind of spiritually direct way and to share such knowledge and feeling with others. The philosopher, poet, musician, and artist are more often revered in this culture than the businessman or financier.

The Anglo's tendency to judge others largely in terms of the absence or presence of material comforts which he values so highly may cause him to perceive the Mexican American as "culturally deprived." This ethnocentric attitude on the part of the Anglo implies that his standards are the only "right" ones."

Lecture and Group Discussion

What Value is Ethnocentric Aging?

People everywhere tend to believe that the way they live and the organization of their society is typical of the whole world -- or at least desirable for everyone. In other words, they are ethnocentric. Actually, we can learn a great deal about our own culture and the values we assign to the aged by looking at the value systems and the role of the aged in other cultures and ethnocentric aging.

Much has been written about the people of Abkhasia in the republic of Georgia, a region of the Soviet Union, many of whom live to be over 100 years of age. A similar group of people live in the village of Vilcabamba in southern Ecuador; 16.4% of the residents here are over 60 years of age, a number of them well over 100. They live by crude farming in a mountainous terrain which requires continuous and vigorous activity. The old people engage in the same kind of work and there seems to be no point at which they expect or are accorded any special treatment. Their daily calorie intake is about 1700 calories, they eat very little meat, no milk, butter, or sugar. Vegetables, beans, corn, barley, and a few native fruits make up the diet. All are generally slender, well muscled, and have a youthful appearance. There is little disease and no incidence of cancer, heart disease, ulcers, or bone fractures. There are no doctors in Vilcabamba, but cures with herbs and special teas are practiced. A significant factor seems to be the tranquillity with which they face any problem. They serenely make the most of a life that offers no superficial luxury, and seem to derive enjoyment from their environment.

In contrast to this simple society, the Scandinavian countries are highly industrialized and maintain a high standard of living. These countries are more welfare-oriented than the United States and provide higher pensions. They offer optional employment opportunities to people past retirement age, and provide many health care services, both institutional and at home. Most of these countries provide educational and recreational programs for older people, as well as special housing and rent supplements.

We may well examine the aged in Japan, both in terms of services provided, and in particular the changing roles. The stereotype has long been that of a people upon whom the younger members bestow honor, respect, reverence, filial piety, and loving care. The true situation is that the status of the aged in Japan has declined greatly since World War II, along with many other changes that have occurred. Although health care is provided by the government, as well as educational and recreational centers, six out of ten older persons are completely dependent upon their families. The old social establishment and the traditional value systems have been overthrown as the younger people have moved into a highly industrialized society. Retirement is encouraged at age 55 but pensions do not begin until age 65, and new employment can be found only at very low pay. There is a growing trend for the older persons to live in separate residences, and many have great difficulty financially.

Caring for aging parents is still viewed as "a good custom" or a "natural duty," but the custom is practiced less and less, and the older people themselves are beginning to seek some kind of independence from family support. The suicide rate among the elderly has increased, which reflects one way of dealing with the changes in status. One note of a more positive approach is the development of organizations among the aged for the purpose of seeking more rights and privileges.

As we look at the Asian elderly in our own society, we must remember that they come from the earlier period of history in their native lands which did bestow upon them the respect, honor, and family care which is a part of their understanding of life. Brought here as cheap labor, thrust into stereotyped work roles, victims of repressive and discriminating legislation, they have often developed fatalistic attitudes and some are unaware of the larger society and the possibilities for political power.

Many of the immigrants who came here were from ethnic groups which believed that it was a definite duty of children to provide care for parents and grandparents, and whose native governments decreed such care by law.

Although our own culture gives great emphasis to being independent, even in old age, the late Margaret Mead questions this value system which compels our aged to live separate from their families and from the younger generation. Mead observes:

> "The young need to know about their past before than can understand the present and plot the future. Young people also need reassurance that change does not mean an end to the world, but merely an end to the world as they first saw it."

Segregating age-related programs is more evident to the Anglo culture than to minority groups. Minority cultures for a variety of reasons (not the least of which is cultural survival) tend to address needs from a multi-generational perspective. Thus, for minority elderly, it might make more sense to design services into a multi-generational approach. For example, the cost of establishing a separate system of health care for the elderly may outweigh the cultural responsiveness. Perhaps the real key is not whether services are segregated, but rather whether they have mechanisms for addressing language and cultural differences. Every mainstream service provider ought to receive training and orientation by minority representatives to provide some perspective on other cultures.

From the Report of Proceedings of the Fourth Institute on Minority Aging:

> "Cultural variables, norms, and values of each minority cohort are paramount factors in determining why one technique which has proven to be successful for one minority community may not be appropriate for another community, or for different ethnic minority cohorts. Programs and services must be designed and adapted to fit particular ethnic minority needs and life styles."

Integrating the aged into the mainstream of our lives rather than excluding them has genuine merit. The aged can be valuable models to us. Their experience and understanding of people, events and circumstances can help chart the course of our lives. They can teach us that we are not just growing old, but that we can be old and still growing!

So many people I have never known,
So many lands I shall never see;
And yet all nations of the past
Contribute blood that flows in me.

Of all the ancient hopes and greeds
I am the small, yet infinite sum;
And even now I bear the seeds
Of states and histories to come.

Jessie T. Ellison

Sources for the above material:

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SOCIAL GERONTOLOGY WORKSHOP
UNIT #4
CULTURAL VALUES AND THEIR IMPACT ON OLDER KANSANS

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 124, Benton Conference Center
Tuesday, April 17, 1979

Session #14
CS 314C
The Indian Elder

Resource Leaders: Liz Munoz, Community Developer
People Helping People
Jeanne C. Tucker, Director, Gerontology Institute
Washburn University

Suggested Agenda

Introductory Lecture:	Hanta Yo -- Clear the Way
Photo Essay:	How do we preserve the ancient rites and traditions?
Move and Lecture:	Desert Soliloquy: The Hopi Way
Lecture:	What is the value of oral tradition to all cultures?

Objectives of session #14

1. Discuss the demographic profile of the older Indian
2. Discuss the difference not only in language, but non-existence of some words in the Indian language.
3. Increase the awareness of the ways in which the Indian elders have preserved their culture and transmitted their history.
4. Discuss how ethnic differences in value systems affect the Indian's perception of the value of aging and the aging process.
5. Present materials on the significance of oral tradition and the Indian heritage.
6. Increase awareness of cross-cultural expectations of Indians and non-Indians.
7. Explore the similarities of oral tradition in all cultures and the changing role of the older person.

Introductory Lecture

Hanta Yo -- Clear the Way

Hanta Yo is a current best selling book by Ruth Hill that was not intended to be a best seller. It was written by a 65 year old woman who lives on a remote island in the Pacific Northwest. She spent over 28 years researching and writing this painstakingly authentic saga about American Indians around 1800.

Hanta Yo -- a Sioux term meaning "clear the way" focuses on two families in the Sioux tribe over the three generations prior to white man's encroachment on their lands in the Grand Tetons. Chunksa Yuha, a full-blooded Sioux was the keeper of oral traditions for his tribe and had long searched for someone to help him write the stories he'd been told by his ancestors.

Ruth Hill had been fascinated with the Indian's oral traditions since she won a prize for an essay she wrote on Indians, as a child of nine. For this book, she had written a 2,000 page manuscript based on her interpretations of the surviving records of a band of Teton Sioux. As she worked with Yuha, he convinced her that she could only convey a true sense of Indian consciousness by learning the Sioux language and re-casting the book with an Indian perspective. It was translated from modern English into the now archaic Dakotah/Lakotah dialect and then re-translated into an English based on the Webster's 1806 edition and faithfully reflected the Indian idiom.

One of the major problems of discussing the needs and concerns of the Indian elders is this lack of translation. Service providers tend to measure services in terms of the value systems held by non-Indian planners. Trying to understand the philosophical foundation for the values held dear by the Indians has not been included in the translations. The non-Indian designing programs for the Indian elder often does not understand the oral traditions and Indian idioms that are the foundation of the Indian value system. As Chunksa Yaha explains in his narrative about Hanta Yo:

> "Before starting to work together, it was essential that I and the writer establish a terminology beginning with an understanding of what the Dakotah meant--and means--by spiritual. The Indian, I told her, begins with the spirit of man and works down through the laws of the universe. Taku skanskan, I said--something in movement, spiritual vitality. Taku skanskan, I repeated! All the religion there ever was in that one phrase."

So much can be said by one phrase--and so little can be said by the years of myths, false stereotypes that non-Indians have translated as Indianness.

Photo Essay

How Do We Preserve the Ancient Rites and Traditions?

Over 40,000 photos were taken by an early photographer, Edward Curtis, over a thirty year period. A collection of his brown and white photos were used as a photo essay on the Over Easy television series and narrated by Hugh Downs. The photos and narration illustrate the deep reverence for nature held by the Indians and capture the essence of early Indian life.

Curtis had a deep desire to preserve as many of the various sacred rites and traditions of the Indian culture as he could with his camera. He lived with the Indians, learned their religious rites and participated in the ceremonies while making his photographs. The narrative emphasizes several discussion points:

1. The old Dakota is wise, he knew man's heart away from nature becomes hard. He knew lack of respect for growing, living things soon grew to lack of respect for humans.

2. Guard your tongue in your youth, and perhaps in old age you may mature a thought that will be of service to your people.

3. The power of the world is in the circle--everything important is in the circle--the sky, the earth--the family as it draws in old and young members--life itself from birth to death. The tipi is round and the village tipis are set in a circle to form a nest where the children are born and trained.

4. Our religion is the tradition of our ancestors, the dreams of our old men, given to them in the solemn hours of the night by the Great Spirits.

5. Our dead never forget the beautiful world that gave them being and they never leave it. There is no death--only a change of worlds.

6. Indian people have never been ashamed of growing old. They merely accept it as a fact of life because they understand the forces of life and the forces of nature, that everything that lives also decays.

Movie and Lecture

Desert Soliloquy: The Hopi Way

The film describes The Hopi Way -- and the cultural differences that can make it difficult for an Indian to live successfully in the white man's world. Differences in values are illustrated in the life cycle development, the family role and religious beliefs.

1. Life Cycle Development

The Hopi baby is kept very close to the family, mother, older sister, a grandmother. Sometimes they are bound on a cradle board, which a white person may view as cruel but which the Indian narrator says did not seem to make him feel restrained. The Indian child, when freed from the cradle board is completely free to do as he desires. Discipline is not rigid and he can eat when and what he wishes. There are only two don'ts in childhood -- don't go too near the fire and don't go too near the edge of the cliff. He is allowed to explore and grow and learn his role in the extended family. Because of the acceptance of his family, the Indian child finds the world an accepting place and establishes a positive self-concept.

2. Family Role

The parents are concerned with the survival roles, hunting and growing and preparing the food and providing shelter. The grandparents and uncles and aunts play an important role in the teaching and disciplining of the children. Punishment, as the child grows older is administered by an uncle, rather than the father. The grandparent's role was to tell stories about the earth, the birds, plants and animals and to intervene when the Kachinas came to punish for a wrong done by the youngsters. The parents introduce the children to the rites of adulthood, and they learn by imitating the work role performed by the older men and women. The grandparents were revered because it was believed that having lived a long life, they would have more knowledge and greater wisdom.

3. Religious Beliefs

The Hopi child learns from his elders that the whole world must work in harmony with the gods, the earth and with each other. They are taught to "praise what others do; belittle what you yourself do." The value of communal good, or working for the family, the village and the earth -- rather than individual achievement is excelled. The Kachina ceremonies impress upon the young men the possible harshness of life and that they can survive the stress of known and unknown anxiety if they do not try to force nature but accept each day at a time and each hardship.

The Hopi child may experience confusion when they attend school in the white man's value system. They are expected to compete and excel--to be competitive and first, rather than work for group goals. Textbooks and white teachers may have a cultural bias that is sensed by the young Hopi student and can affect their self-image and further confuse them. There may also be a language problem, for the native language of the family may be scorned in the schools and textbooks and phrases of the English language misinterpreted.

As the young Hopi continues his education, further conflict of values may develop as they relate the education to future life goals. The white counselors advise training for a job that will allow him to live financially secure in the white man's value system. But, the young Hopi wishing to preserve his own Indian cultural heritage may feel drawn to returning to the family life of the reservation.

Wealth, personal status and prestige are not primary values in the Indian culture. Their ancient culture has emphasized survival in a harsh land, which has always depended on group thought and action. The rituals and traditions of their religion have been misinterpreted by tourists as meaningless dances by individuals in grotesque masks. Jewelry, Kachina dolls and sand paintings are collected by white men for entirely different reasons than the value the Indian attaches to them. To the collector, they are interesting to the eye, but to the Indian, they are meaningful to the soul.

The value of group action can be seen many times in the present Indian culture. Examples of the power of this viable group effort is illustrated by their group effort to restore mental health. Navajo relatives and friends of an individual who is in need, will leave whatever task they are undertaking in the non-Indian world, and gather for healing ceremonies to cure their sick member. They will gather for several days around a huge bonfire and sing and dance the religious songs and concentrate their efforts to help the sick person cope with their problem. The healing power of realizing that a group of people care about you and your problems can bring about cures where the white man's medical science fails.

Many of the elderly Indians refuse social service help when it means being separated from their families and familiar surroundings. Because of the conflict of value systems, social service workers may be confused when an older Indian will not leave a seemingly sub-standard living arrangement and move into a "better life." Leaving the group for an Indian may not only change their geographic surrounding but may take them away from this vital group support.

The conflict of values and preserving the richness of Indian heritage can cause an older Indian emotional stress and anxiety. Alcoholism has become the number one social problem among the Indians in the southwest. Perhaps this is a defensive behavior to cope with attempting to reconcile two different value systems and keeping ancient traditions alive while existing in a fast moving, competitive society. Suicide rates among Indians is 45% higher than the national average. Adapting to the changing

values in the "difficult and nervous" contemporary American life style and retaining their Indianness may overpower the younger Indian. It is difficult to integrate an entire nation into another. Acculturation is a better way. Retain the native culture and religion and things dear to the Indian and utilize these values in the non-Indian world. Perhaps the parallel with aging problems exists in how far society should go to take the Indian away from his Indianness--and how far should society go to take the older individual away from familiar surroundings and support systems.

Lecture

What Is the Value of Oral Tradition to all Cultures?

One of the greatest values of the Indian elderly is that they represent to us a repository. With the media impact of television and movies, our concept of Indianness may be inaccurate. The oral tradition handed down from ancient times brings to focus the different remembrances of each tribe.

The movie "A Man Called Horse" dramatized an old lady being put out in the snow to die because she no longer had children to care for her. This may or may not have been the practice of the Sioux that were depicted in the film--but it was not the practice of all Indian tribes.

Each tribe has a different history and a different knowledge of where they came from. Anthropologist debate that the Indians came across the land bridge from the north--but some Indian tribes tell the story of a long, difficult journey from the south. Dances depicting hardships, starvation and death along the long trek are handed down along with the elder's story telling of the journey from the south.

As the different tribes settled in the United States all with different histories, so were the cultures different. The Pueblos were the first city dwellers, building two to three story high living arrangements. They were farmers, staying in one place with the value of inter-dependency strong. The last thing they would do would be to put the old woman out in the snow to die. In their tribe, everyone worked together as a unit to survive. There was not the pressure of individualism and the concept of I and you, but of us.

The grandparents had a positive influence upon the children. The young women, the mothers, were busy with hard, physical work. The grandparents were the ones who took the children on their knee and told them the story of their heritage. And it was to the grandparents that all went with problems--for they had survived longer and had more wisdom and experience.

The Indian oral tradition stressed that all should be in harmony with nature. The stereotype of passive and stoic Indian is the heritage of this oral tradition. "Don't force nature. Accept life as it comes to you. If you try to force, perhaps it is not ready to happen."

The dances, songs and rituals were dramatic methods of emotional reenforcement of this oral history. The Kachinas and other characterizations brought the story dramatically to life. Today, the Indian elders are preserving what is left of Indianness. As contemporary Indians vacillate between the two worlds, the respect for nature and respect for life are values that the elders still instill in the young.

The recent interest in finding our "roots" illustrates the accuracy and value of oral tradition. Unwritten history passed from generation to generation arrives in current history surprisingly accurate. The ancient oral traditions of respect born from the Indian culture is a beautiful tradition that the Indian people could share with the non-Indian world.

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SOCIAL GERONTOLOGY WORKSHOP
UNIT #4
CULTURAL VALUES AND THEIR IMPACT ON OLDER KANSANS

WASHBURN UNIVERSITY GERONTOLOGY INSTITUTE
Room 124, Benton Conference Center

CS 314D
Our Midwestern Cultural Heritage

Resource Leader: Nadine Burch, Certified Advocate in the Field of Aging

SESSION #15

Suggested Agenda

Introductory Lecture: Aging in the Rural Environment

Video Presentation: The Years Ahead: Aging in Northeastern Colorado

Lecture: An Old Woman Speaks: Our Midwestern Cultural Heritage

Group Exercise and Discussion: Epilogue: What is this Thing Called Social Gerontology"

Objectives

1. Discuss the advantages of intergenerational advocacy for social planning for integrated services to benefit all age groups.
2. Discuss the impact of ageism.
3. Discuss social planning requirements to meet the diversity and uniqueness of older Kansans.
4. Discuss midwestern values and how they affect social gerontology.
5. Discuss the values of grassroots participation and its relationship to midwestern cultural values.
6. Present visual and audio stimuli to portray the characteristics of our midwestern older individuals.

Introductory Lecture

Aging in Rural America

Individuals in small communities and rural settings know a lot about each other. They know who has the power; who makes the decisions and who doesn't in their geographic surroundings. They know who is on welfare, if indeed, anyone is. They know who got a raise and who was fired. They keep close track of how the crops all over the county are doing and whose corn is higher and whose wheat has rust. They know the city officials by their first names and know the mayor's children, mother-in-law, sisters, brothers and who is related to who. Residents in rural settings know their history personally. They are able to record events on a first name basis and a first hand knowledge.

But even with all this knowledge, we must remain sensitive to the fact that it is impossible to label all rural Kansans as a homogeneous group. They are unique individuals and become even more unique as they grow older. The quiet, loner who said little as a youth, will probably be a quiet older person. The talkative, active farm wife will likely be an individual who still enjoys active, social interactions as she ages. The devout Catholic who has never missed a mass, and the non-church goer all live on our Kansas farms. Ethnic backgrounds, religious beliefs, personal behavior patterns are varied for the young and old alike -- but there are several values that seem to be shared by the majority of the older Kansas people with rural backbrounds.

Independence, or the American value of being in charge of your own ship of fate. The heritage of the early pioneers that carried their own weight and were beholden to no man still lingers among mid-western values. Interdependence was an accepted fact; you help me raise my barn and I'll help you harvest your crop -- but, it was a shared dependency and allowed for reciprocal behavior. If one had to depend solely on the church, or a social agency, there was a sense of shame and guilt and a hesitancy to seek or utilize "charities."

The Protestant work ethic was strongly interwined with this spirit of independence, with hard work being next to Godliness. Back bending efforts were required to survive on a prairie that may or may not have enought water to grow food, and provide for the survival of the early settlers. Everyone was needed to tame the wilderness and make it a hospitable environment. Those that shirked their responsibilities were given low status. Twinges of guilt spring from this value as the mid-westerner ages and finds that his physical energy level no longer allows him to toil in the sun all day, or forced retirement takes away the work role

This sense of independence included the right to make choices -- free choices. You were in charge of your destiny, and had some sense of power in controlling your life course. As the media daily brings world problems in with our breakfast, this feeling of control slips, and older individuals experience stress because of the conflict with this basic value that was processed during a different era.

It's a fast changing world -- and growing all around us. Small towns are becoming big towns and farms are now inside city limits. Older individuals used a good deal of their youthful energy building structures, and farming lands that are now suburban home sites and changed environment. As sturdy homes were built, a sense of lasting contributions that would endure long after they were gone was

a value that urged the family to make sacrifices to leave a legacy of stone and brick. Now, many of these structures are symbolic of the razing of the traditional ways of life for the mid-westerner.

Have you ever watched a Kansas sunrise or sunset? Somehow they are always different, but always the same. Living in the short grass country gives you a pretty clear view of nature's handiwork: Somehow as clouds build on the western horizon, you come to respect the power in a force that is larger than life. As their forefathers learned how to cope with this power, they found certain techniques worked, and other failed. Utilizing this rational, logical "down to earth" knowledge causes some problems in being labeled conservative and reticent to change. Knowing that certain ways of life have worked for others, and not being sure that trying new ways, just for the sake of trying new ways, will make life more satisfying, seem to be an internalized value that carries older Kansans into that "conservative category."

Personal honesty and candor are other mid-western values that affect the hardy old timer. You don't go up to someone and inquire about personal problems, but you have repeated personal interactions and find out through individualized interest. Outsiders coming in and asking personal questions are violating values of privacy and confidentiality. But, there is a certain candor that is allowed among old friends. If there is a disagreement, it can be discussed -- and if things are not to your liking -- you can tell someone about it in a honest, sincere manner. Crime against your neighbor is not a common way of thinking and the rising crime incidents both in cities and in rural areas go against the grain of this integrity fabric of the mid-westerner.

The rugged individualist and the spirited free thinker still exist in the mid-west are sometimes unmined resources. To paraphrase an old miner "Thars a lot of gold in them there plains." We need to be sensitive to these family jewels and care for them wisely.

"THE YEARS AHEAD:

LIFE FOR THE AGING IN NORTHWEST COLORADO"

There was time. .Time to be alone. I hear kids today saying I've got to find out who I am. That never occured to us. We knew who we were. If you wanted to just sit and watch the birds, or listen to the wind in the trees or the wheat wave---you could. Children don't have that opportunity now. We had a greater sense of values. Maybe it was from part of the church, the home, and the school. I think there was time and space on the farm that became part of us.

The thrill of Lindbergh was fantastic. All of us just couldn't take it all in. It was almost too much for us to understand. I think I've lived in one of the most wonderful eras of all time. Like going to the moon. We knew they couldn't do it---that was impossible. The moon was made of green cheese; everybody knew that. So when Neil Armstrong stepped on the moon we thought our hearts would burst!

Mary Warrender, New Castle

"It was a very nice feeling when you knew everybody you were dealing with and didn't hestitate to give anybody credit. Anytime there was sickness or tragedy in the community a town without a doctor had a druggist which was the nearest thing. You became a very vital link in the community.

During the Depression we took care of our customers whose income was their cream check. An average five gallon can of cream brought from $1.39 to $1.56 and that was their spending money. They bought their groceries, kids' shoes, and medicines all out of that. I've said, 'Johnny has a cold and a cough." So I'd put out five cents worth of epsom salts in a paper sack, and I'd give them some turpentine. I would probably charge them five cents---maybe ten cents, but it was a ten cent bottle. We went behind every day, but in either store we never turned anybody away without medicine.

That's how you get close to your community. It's doing for somebody else and they were doing for us. The good times don't make you friends; we're at the heighth of that right now. Nobody needs to be beholding to anybody. But if there comes another depression, it takes the whole community to pull everybody through.

Doris Flynn, 81 yrs., New Castle

"Carrots, potatoes, right out of the garden. That's the best medicine you can eat. A whole lot better than what you get at the supermarket. We're not buying that stuff; we're harvesting it ourselves. I think that the young people should know more about agriculture. How many people really know how to grow a potato?"

Melvin Branson, 76, Plateau Creek

"This program received financial support from the Colorado Humanities Program (CHP). CHP provides funds to non-profit Colorado groups who wish to sponsor a discussion of public policy issues which bring together the general public and humanities scholars. For more information write CHP, 855 Broadway, Boulder, Colorado 80302, or call CHP at 442-7298."

"As long as I'm able to keep my home going I want to be by myself. I'm just that independent. I like to get up when I get ready and fix my meal. I'm usually up and puttering around here at six o'clock in the morning. Whereas other people stay and rest until eight o'clock. I thank if I can go out and work in the garden while its cool then if I have some time I lounge around in the afternoon.

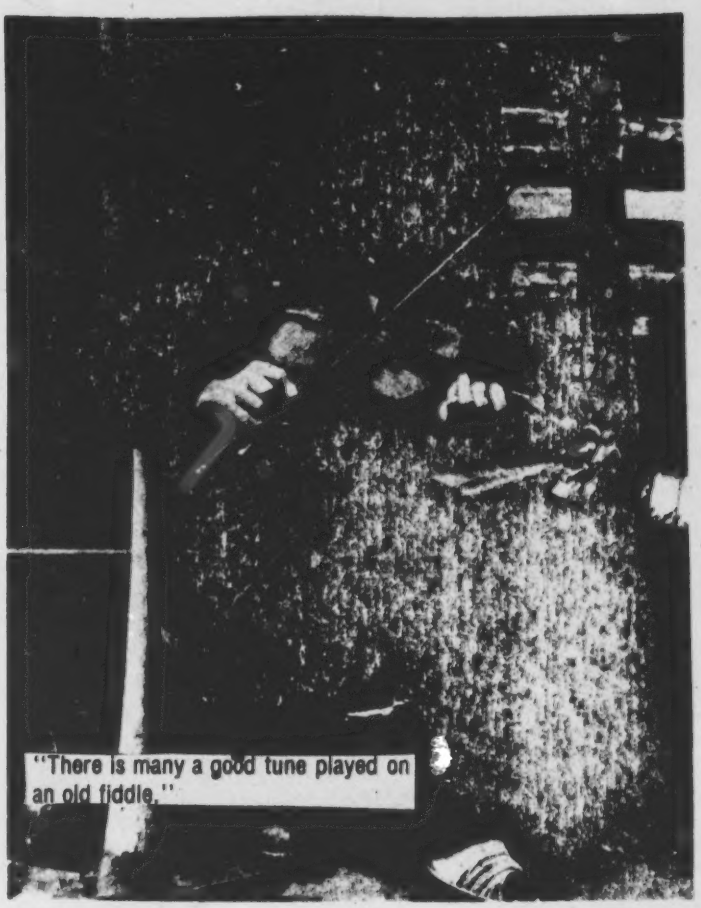
When you creep up to 83 you know that a good many of your friends and loved ones have already gone. Just understand that that's the way of life. We all have to come to the place when we see our loved ones are ill and we have to say 'not my will, but thine, be done.' They are suffering, we know they can't get well. God knows best. We have to learn to accept things and go on as we can.

While we were young we were just ambitious and doing things and keeping our homes going. Now our families have finished school and are by themselves and we have to look forward to go on to our reward. I hope the time will come when we'll all be up there together, and I hope that Chester and the three boys are a busy building a little mansion up there for us. I don't want a big, big mansion, just a little home where we call all be together."

Nellie Johnson, Craig

"I'm a better man than I used to be. It doesn't take me all day to put in a day anymore. I work by the hour, and if I get too tired I can just come back tomorrow, but if I have a job that takes eight hours or ten I'll just go on and do it. I want to work until I'm a 100, and live until I'm a 108. Then I want to die. I believe that's long enough to live, don't you?

Jim Farris, 72 yrs , Silt



"There is many a good tune played on an old fiddle."

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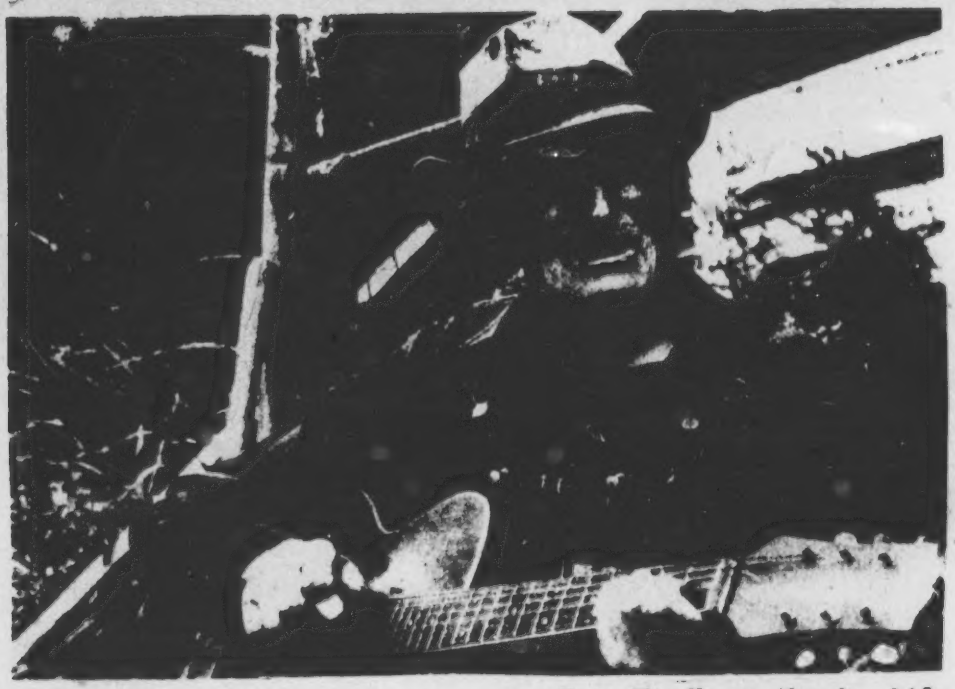

We Did It
composed for the 1976 Kansas
Governor's Conference on Aging

We did it

(Tune: "Old Time Religion")

1. In youth we came to Kansas;
We endured many hardships;
We learned to love our neighbor
And build society.

Chorus:
We are Kansas senior citizens;
We are Kansas senior citizens;
We are Kansas senior citizens,
And we're proud as we can be.

2. Persevering and active,
Persevering and active,
Persevering and active
To make our wishes known.

3. We seek a brighter future,
A determined generation,
And we'll seek until we find it,
And that's our victory.

4. We are a source of wisdom
To give guidance to our country,
Determined to help each other
find peace and harmony.

From The Years Ahead: Life for the
Aging in Northwest Colorado

"WE'RE STILL DOING IT TODAY"

We're the old ones who raised up America,
We're the old ones who helped her grow.
We plowed up all her fields,
We cut her acres of hay,
And we're still doin' it today.

We're the old ones who built up America
We're the old ones who helped her stand.
We ran the railroads.
We mined the silver lodes,
And we're still doin' it today.

We're the old ones who grew with America
We're the old ones who gave her strength.
We worked the ranches and farms
With the might of hearts and arms
And we're still doin' it today.

We're the old ones who gave birth to America
We're the old ones who brought up the kids.
We baked the pies and milked the cows,
drove the tractors and fed the sows,
And we're still doin' it today.

We're the old ones who love our America.
We're the ones who always worked for peace.
We used our skills and tools
to build the churches and schools,
And we're still doin' it today.

lyrics by Stephanie Moran

music by Dan Talenske (c) 1977

Excerpts from Aging in America,

Bert Krueger Smith

Prologue

An Old Woman Speaks

What is the sound I make when I am old? Shuffling for sustenance, napping for strength, dressing for no one, waiting for one certain visitor, I am a diminished me. No capital I. No self to fling free, a bird sailing skyward. There is only a small i, shriveled within the layers of the years.

Somewhere in the early sleepless morning, when daylight still brings flicker of promise, I lie young on my scarcely wrinkled bed and am warmed by the feel of husband-hands caressing me knowingly or of child-fingers on my face or of friend-touch on my hands. But those moments pass. Daytime brings no warmth, and at last I rise because I have always risen and go to prepare myself for a day which stays too shortly and a night which comes too soon.

I am an island, barren, surrounded by the waters of my life, my own shores drouth-pounded, desiccated. Only echoes skim the waters to my island-world--whispers and words, songs and laughter, carried by satellite of memory into my solitude.

Hands lie heavy on my lap--vein-ridged, spotted. Once they were like white birds in graceful flight over keys of a piano, stirring savory pots of food, gentling a crying child. Agile, useful, they were never still. Now they too are done with reaching out. They are folded inward.

Memory teases me, evanescent, transforms me in a breath of time into a bride holding fear and hope inside my white voile wedding dress. I am young and breathless with excitement. . . . No, i am old and breathless with fatigue.

"I know; I know," they say. "There are problems with being old." But they do not know. Everyone has been a child. All can understand through muffled memory how childhood was. But none has been old except those who are that now.

Who can speak for the old? And who speaks to us? Once, when I was very ill, I lay unmoving on a bed. The doctor-voices, nurse-rustles all came to me, barely sounding through the layers of pain which separated us from one another. They talked about me then as if I were not a feeling, hearing human being. They talked above me and around me as they prepared needles and moved limbs. It was as if I had left my body there to be tended.

And now it is the same. No one looks at me--at me, into my eyes, into the core of me. It is "as if" I am like all who have lived too long, a being to be tolerated or bypassed or humored.

Can no one see that within my soul I exist? The person who loved and grieved and was? I too have hungered, been tormented by passion, known knife-thrust of pain. Stir the ashes of my being, blow tenderly to bring the flames to light.

Once I too walked through the hills in the near-rain. The trees were etched clear green, while new-wet brush in the distance seemed filtered like an unfocused picture into vague designs.

So with youth and age. For you who are young, life is close, free-form, clear-colored, significant. For us who are old, the distance of the years turns images into misty shapes, unclear and undistinguishable from one another.

In the daytime, life moves to the cadence of activity. Voices sound down the street, in the house, through the radio. Music plays somewhere. Cars cough; lawnmowers grumble. The teapot whistles.

But at night, the sounds are muffled under a pillow of darkness. The people-noises disappear, and things become animated. A window shade taps on and off in the breeze; a tree whispers against a glass pane. A floor board squeaks and a furnace growls.

The night is stil and very lonely.

The autumn sun cannot warm my bones. Yet this day is mine, lying new-born like a shivering duckling in my hands. Can I create of it a memory to note with others in the album of my life? Will I live it, or endure it. I make the choice, knowing that life is not a picture postcard, caught forever at a moment of romantic beauty. Venice with its gondolas and singing boatmen is also Venice with problems of pollution and unemployment. Only memory, or love, or will can pin the butterfly wings of a moment onto the board of time.

To create that moment is to be open, a cup to be filled from the sweet essence of experience. To lie in the heart of life, co feel the pain of a stranger or the joy of a friend, is to be alive--fully alive at any age.

Bring me to soft fire that I may still give warmth to others . . . .

Epilogue

A Young Person Responds

I see you, old woman. I see the You, not the old. In your eyes I read the story of the years, of the pain, the sweet delights, the tender pain. I see you, Woman, know your femininity, your graceful movements, your healing tenderness.

I uncover the swathing of the age and view you young and human and womanly. If I see you, if I can feel your pain, if I can know your joy, you are not alone. You are not a small "i" far away like a stringless kite.

I know you, woman. Your blood flows in me. I am of your soul. The dreams you dreamed have come alive in me and in those around me. Your wrinkled flesh grows firm on me. Your dried seed takes life. For if we are not part of one another, if we cannot carry forth delights and dreams, we do not live collective lives but die apart in singular death.

Look at me, woman, as I look at you. See--we know each other; we are part of the same rainbow. Your colors flow into mine; mine fade into yours. We are the same combination of sun and rain and reflection of life.

There are those who look at you and say, "She is childish." But I view you, look into the depths of your eyes, and I say, "She is child-like." To be childish is to be petulant, temperamental, unwilling to endure frustration or punishment or misery of any kind. But the slashes which make parentheses around your mouth show pain long endured and seldom vocalized. Your eyes bear imprints of tears shed and sorrow felt. Those are not the symbols of childishness. Yet you are child-like. For along with the signs of hurt and tolerance I view also the quick lights reflecting delight at life's newness. There are traces of laughter, and in your age and your tiring body there still resides the child who can awake to wonder and to the miracle of a light which is just beginning to trace gold lines on the wall of a room.

You are child-like, old woman, in your marvel at today's dawn.

Old woman, I do see the you that was and the you that is. I see you young and vigorous, full of family and love and the busyness of baking and soothing and training and cleaning.

I see you in the nursery rhyme. You still remember it, "There was an old woman who lived in a shoe. . ."

It wasn't exactly a shoe you lived in, but it seemed crowded like one when the children were young and the walls rocketed with noise and the beat of swift-swing music. When the stairs were lined with skates and books and spring-green sweaters. When the kitchen was jammed with youngsters opening the icebox, inspecting the cookie jar, leaning on the drainboard to watch the supper process.

"There was an old woman . . ." You weren't old then. You just felt it at times when fatigue nibbled at the calves of your legs and beat against your spine. You were only old against their youth, their exuberant, endless, energy-filled youth.

But now you are an old woman. And the shoe is empty. Walls quiet as watchmen on the corner. Stairs waxed, shining, empty. Kitchen big and peopleless. No smell in the kitchen except soap and disinfectant. No sound in the house. Just an old woman and an empty shoe.

You still have so many children you don't know what to do. Mainly because each child has the solution to your old age. And no solution fits you, any more than someone else's shoe can match your foot. Each child wants to uproot you, place you in a new shoe, in one which has not softened to your shape with the passing years. No one could know that, quiet as the old house is, it still holds within its walls the long-forgotten sounds of a young boy's laughter or a tiny girl's sobs.

This is the shoe which you feel will fit you until you die. You want to stay where memories are echoes which sound at night. You want to gather all the years into the pocket of your self and hold them to you gently, fondling them like beads in the rosary of your life.

You will not wither in total loneliness--solitary, away. My hands and those of people around me will reach for you in the dungeon of your alienation, will lift you, carefully, into the slanted sunlight of our lives.

Our fires will bring you warmth; our companionship will give you strength. We will widen our circles. We will sprinkle you with our laughter; we will feed you with our concern.

Our children will touch you; the flushed warmth of their hands will penetrate your own.

We will open doors and invite you into the room-brightness of our lives.

I see you, old woman. But even as I look, your face turns into my own. We stand at opposite ends of the same long corridor, reflecting the image of one another.

Lecture

Our Midwestern Cultural Heritage

The characteristics which we attribute to people in the midwest are clearly seen in the lives of its older people. Some are cultural values which we prize and admire, some may be attributes which we feel are not so desirable, but they all have an impact on the behavior patterns of our elderly. An outstanding example of the influence of these components of the midwestern value system can be seen in the life of an older Kansan who shares her experiences in recent years as she came to grips with the need to make a new life for herself. The strengths of independence, determination, perseverence, candor, sensitivity have enabled her to deal with the myths and stereotypes which often prevent weaker persons from succeeding.

A person who has labored against many odds in her pursuit of a better life for all older persons, this woman has gained the respect and admiration of all who work with her, whether it be in a college setting, governmental agency, advocacy group, or working with individuals.

After working nine and a half years for the Veterans' Administration, Mrs. B. was given a disability retirement at age 59. Her previous employment and that of her husband had not been covered under Social Security and her short term employment with the V.A. did not produce very much in the way of retirement benefits. She says that for a whole year she felt like a "nothing!" Her financial situation made is necessary to find work so she became a homemaker for a widowed college professor and his three young children. Although she was happy in this situation and was really only expected to be a grandmother figure to the children, her health made it imperative that she leave. She accepted the invitation to become a housemother at a fraternity and says that she grew immeasurably from this experience. Meanwhile, she was taking a few courses at the college and after two and one-half years was ready to move into a new endeavor.

Mrs. B. became the site director of a nutrition program in a high rise apartment for the elderly. She says that, in retrospect, she believes that up to this point in her life, she had tried to keep away from her peers--she did not want to be old. Being with older people in her new position bothered her at first--their rigidity, their conservative ideas. They kept saying to her, "Why do you want to work? Why don't you retire and just rest or have a good time, the way we do?"

Then Mrs. B. began to see that there were no programs or services in this country to meet the needs of older persons, and so along with other concerned citizens, she began to explore the possibilities. She helped to set up a county council on aging and to develop various kinds of services.

As she became more and more involved in the training and educational aspects, she felt the need for some training. Because of her disability status, she approached the state Vocational Rehabilitation Center for help with training only to be told that they could not allocate funds to train old people. Undaunted, she wrote to her congressmen in Washington, and eventually received the approval for her training. Along with staff members on the faculty at Kansas State University, she helped to develop a

curriculum which would meet her particular needs and fill in the gaps in her work experience.

Upon completion of the academic work, she had a year of field training with the local Area Agency on Aging and received a certificate as an Advocate in the field of aging. A grant from CETA enabled her to work as a coordinator for an environmental program, but she states that she has difficulty finding employment due to the lack of an academic degree.

She continues to lecture and to lead workshops related to Gerontology, and always to be a strong advocate on various boards and committees. She points out that midwestern states have had difficulty getting funds for programs, due in part to a cultural belief that says "old people want to be independent; if they can't take care of themselves, the neighbors will do it," and "people are too proud to accept free services." The facts are that many older people in the midwest do need programs and will use services which are properly identified and explained.

Many older people will have nothing to do with mental health services--you just do not admit that you have problems which you cannot solve by yourself. But Mrs. B. and her colleagues found that they could set up "Enrichment Programs" or workshops entitled "Do you Need to Talk to Someone?" led by mental health specialists from out-of-town--and the older people eagerly participated. She also points out that older people readily accepted many of the same programs from the state agency after it became a distinct department on aging, which they had rejected or ignored when the agency was a part of the Social and Rehabilitation Service or "welfare."

As Mrs. B. worked with others in her county to get support through a mill levy, she came to know many older people, and to admire them. She says, "I had now become proud to be one of them!" She also understood the stereotypes, and knew that they were often "brain-washed" into believing that older people are <u>supposed</u> to be this or that.

She began to see the prejudices against the elderly, and pleads for more older persons to speak out in their own behalf. She tells of a young staff member taking a group of older people on a tour in our nation's capital. He had been extremely patronizing, treating them as if they were children, and finally said to one of the group, "And what did you use to be?" To which the gentleman replied, "I still <u>am</u>, you fool!"

"Old" is not a four letter word, says Mrs. B. Ageism must be met with information, contradiction, education, and confrontation when necessary. We have for too long not stood up for ourselves. We need to be recognized as people. We're not older than the rest of you--we've just been around longer.

Presentation by Nadine Burch, certified advocate in the field of Aging, Topeka, Kansas

EPILOGUE

Ageism and Social Gerontology

Procedure: Participants individually circle what they feel are appropriate responses.

Discussion of epilogue with dialogue concerning possible varied interpretations.

1. Social gerontology includes the study of
   a. biology of aging
   b. psychology of aging
   c. sociology of aging
   d. All of the above

2. People in this country are considered old primarily on the basis of their
   a. chronological age
   b. ability to "do the job."
   c. physical appearance
   d. mental capacity

3. Ageism is
   a. a political movement
   b. a religious philosophy
   c. an aversion and prejudice of one age group against another
   d. a mark of status and respect

4. The number and proportion of older people in the United States
   a. is declining
   b. is staying about the same
   c. is unknown
   d. is rapidly increasing

5. Successful independence in old age can be measured in terms of:
   a. physical mobility
   b. adequate income
   c. self sustained housing
   d. all of the above

6. Aging theories include:
   a. individual and societal disengagement
   b. continuity
   c. activity
   d. all of the above

7. The self concept of older individuals
   a. is unimportant in their mental health
   b. varies by individual personalities
   c. grows more positive
   d. grows more negative

8. Aging is a disease. T or F

9. Where you were when, is what you are now. T or F

10. Ageism can be fought with
    a. education
    b. exchange of information
    c. intergenerational communication
    d. all of the above

1. d
2. a
3. c
4. d
5. d
6. d
7. b
8. f
9. t
10. d

Handout for Group Discussion

What is Social Gerontology?

Social Gerontology covers a broad, diverse topic and unique and colorful older individuals.

U-Haul slows truck, but not 83-year-old driver

CASEYVILLE, Ill. — With her car in tow, Bessie Richardson drove a truck loaded with all her furniture and belongings 1,700 miles from Coolidge, Ariz., to Caseyville, Ill., and now thinks she's through with driving — at age 83.

Mrs. Richardson lived in Arizona more than 20 years before deciding to move from Coolidge to be with her recently widowed daughter, Lillian Molla of Caseyville.

Mrs. Richardson rented a large truck for the four-day trip.

"I couldn't get all my things in a small U-Haul," she said.

She and her traveling companion, Ina Sproul, 78, admitted missing a few turns on the way "because neither of has good eyes."

Mrs. Richardson also said she was annoyed during the trip because the truck would not go 60 miles an hour.

"You can't drive a U-Haul very fast," she said.

"They all said we were crazy," she said. "But I had driven trucks before. And we met the sweetest people. I guess they felt sorry for us because we were old."

But the trip took its toll.

"I think I'm through driving," Mrs. Richardson said.

15 couples married 786 years

WESTLAND, Mich. — A sociologist would have had a tough time convincing 15 couples at an apartment complex party that one of every two marriages eventually ends up on the rocks.

Together, the couples who gathered for the party Tuesday night had marked a total of 786 years of marriage. Each couple had been married at least 50 years.

"This just goes to show that marriages can last," said Jack Horwath, 78, who sat at the banquet table with Ethel, his wife of 54 years.

Edward Long, 80, and his wife, Annie, 82, have been married 58 years — longest of all the couples at the party.

"Sure we're still sweethearts," said Long, winking at his wife.

Gene Reaves, a retired personnel director who played Santa Claus in the J.L. Hudson's Thanksgiving Day parade from 1935 to 1945, was asked his secret for a long marriage. Before he could answer, his wife, Madelyn, said: "Having the right wife."

Reaves said he couldn't argue with that, and never has, which is probably why they were celebrating 50 years together.

Elderly couple found unharmed

MOUNT IDA, Ark. (AP) — An elderly couple whose son reported them lost on the way to a restaurant were located unharmed today after a three-day search in five states, authorities said.

"We were just fooling around and having a good time. We just made them think a little bit," said Ernest Marotte, 84.

Morotte said he and his wife, Teresa, also 84, had driven about 60 miles Saturday night from Hot Springs to Nashville, Ark., where they stayed before driving 46 miles to Mount Ida the next morning.

They ran out of money in Mount Ida on Monday, Marotte said.

"I tried to sell a friend my spare tire to get money for food and lodging, but the sheriff put us up, gave us money for something to eat and took me down to the telegraph office," he said.

Miners Glen Deyo, 84, and his partner, Pearl Smock, 73, are planning to "strike it rich before we die" on a small slice of the Mojave Dessert 200 miles east of Los Angeles where they have been working for seven years. Their camp is 15 miles from the nearest pavement and they have no telephone.

By CHARLES HILLINGER
L.A. Times-Washington Post Service

JEWEL BOX MINE, Calif. — The two partners were walking across the open desert headed for their diggin's, she with a shovel over her shoulder, he with a pick over his.

"We're gonna strike it rich before we die. I've never been more certain. It's gonna happen," mused the younger partner, Pearl Smock, 73, as they plodded along.

"Money doesn't mean a. . .to me. High livin' doesn't mean a. . . ." allowed Pearl's partner, Glen Deyo, 84. "But I think we're onto somethin' big out here."

The two lifelong hard-rock miners have been holed up together in a remote slice of the Mojave Desert 200 miles east of Los Angeles for the last seven years.

It is 15 miles by a dirt road they have blazed over raw desert from their mining camp to the nearest pavement. Their closest neighbor, another miner, is 25 miles away.

"We both hit this spot the same time coming from different directions in '71," Deyo recalled. "I had just come up out of Mexico. My partner had been prospectin' to the north of here. . . ."

He stopped suddenly, knelt to the ground and picked up a rock.

"Look at this. It's silica gel. Mother of all jewels. This whole area is alive with silica gel, a deposit rich in topaz, sapphire and diamonds. That's why we call our mine the Jewel Box.

"See those hills," the old miner continued, waving his right arm in the direction of distant purple mountains. "Those hills are full of copper, silver, gold. Oh, my partner and I know where the treasures are buried out here. It's only a matter of time now.

"I know what it is to strike it rich. I've made it and spent it several times in my life.

"When I've been rich, I traveled the world. Went everywhere, Europe, South America, Africa, all over the 48 states. Had fancy cars. Lived in expensive homes.

"Now, I'm old, but. . .I'm not ready to quit. Not yet. I have the best partner I've ever had in my life. She does her share and then some. That's why I'm glad it's gonna happen again, for my partner's sake."

The two partners paused to catch their breaths. The old man rested his left foot on a boulder, his right hand on his pick. The old woman leaned on her shovel with both hands.

"I was born in a minin' camp in Ideeho," said Pearl as they paused. "I hardly took my first steps when my daddy took me out pannin' nuggets. Been at it ever since.

"Mining always kept me going, always kept me in grub. Never been broke. Not even in the darkest days of the Depression. Durin' the Depression I carried bat guano out of caves in sacks on my back.

"When my partner and I hit it big, I'm gonna give all my riches to poor kids in orphanages. . .I'm too old to spend it on myself. Even if my partner and I don't get rich, we got no complaints. Seven years together in this camp. I have my livin' quarters. He has his.

"He's old. I'm old. So. . .there's nothing wrong being cooped up here together without gettin' hitched. Miners trust and respect each other."

"We get along just fine, my partner and me," Deyo declared with a mischievous grin.

"...few times when we agree. Argue all the time. That's why we get on so well, because we argue all the time. I won't deny that."

Deyo likes Pearl's cooking, too.

"She makes the best. . .pot of beans I've ever had anywhere."

Their shack is warm and comfortable, equipped with stove and refrigerator and electric lights powered by a small generator. Thirty dogs share their grub in the mining camp. A crank telephone hangs in a corner.

"It works," Pearl said. "But there ain't no telephone lines up here." About once a month, when supplies run low, the two partners drive an old truck to the nearest town, a desert hamlet 50 miles away.

"I wouldn't trade my life for nothing," Pearl said.

Going Like 80: Hard Work and Guts Pay Off for Nat Robin

By Diane Stafford
Star Business & Financial Writer

Nat Robin moves one-liners as quickly as he moves product lines at his $1-million-a-year sportswear wholesale business.

"Meyer, here, has been my right-hand man for 2½ years, but I'm going to have to let him go next month. I just found out he's left-handed."

Meyer Fox, second in command at Nat Robin Co., 908 Broadway, smiles but doesn't look up from an order sheet. The pen—in his right hand—keeps moving down the column of figures.

Nat Robin's comedy may not amount to much. But his business sense apparently does. So does his energy.

Robin, who celebrates his 80th birthday today, is not ready to slow down. After a normal working man's life as a traveling salesman, Robin assessed his future and, at the age of 70, went into business for himself.

By 1978, Robin had created a $750,000-a-year wholesale business specializing in women's sportswear and accessories. He lured and hired Fox, 60, who was considering retiring from a job elsewhere in the garment trade.

The company now is enjoying a profit, Robin said, that is better than double what the industry considers good.

"My biggest asset is that I've got a lot of guts," Robin said, apparently taking for granted the robust good health that allows him to continue making the daily trek to his sixth floor office in the heart of Kansas City's old garment district.

A sign above Robin's desk perhaps typifies his business outlook: "If I can't take it with me I'm not going."

John Sullivan, president of Mid-American Bank & Trust Co., helped Robin obtain financing to start his business.

"He was 70 years old going on 30," Sullivan said. "I talked to people in the garment and ready-to-wear industry who knew him. They thought very highly of him. They knew his background."

Robin recalled, "I used to be a traveling salesman. But I started thinking I needed something else. I couldn't hit the road any more like I used to."

Robin said he previously worked as a salesman for Fox Manufacturing Co. and other garment companies. He covered territory in Missouri, Kansas, Nebraska, Oklahoma and Iowa. Although the contacts didn't provide him many financial rewards as a salesman, he said he is thriving today because of that strong base.

"Some of my customers now are the same people I used to call on as a salesman," Robin said, noting that his largest account is in Oklahoma. He named Adler's, the Showroom and Lisman's as some of his current accounts in the Kansas City area.

Robin attributes his success to knowing the sportswear and accessories business from inside out. And he offered a hint that would warm the hearts of Bell Telephone Co. advertising agents.

"I've never written a letter since I went into business," Robin said, patting his telephone. "I use the phone for orders, collections, contacts, everything. And at $800 a month my phone bill is cheap."

Although severe winter weather restricted his traveling salesmen, Robin said his January sales were up 10 percent and his February sales were up 20 percent—a success he attributed to aggressive telephoning.

Robin said his company has between 450 and 500 retail accounts, placing it as a midsized wholesaler in the women's sportswear trade. The company payroll totals 12 persons, including salesmen.

Sullivan noted, "Nat's original line of credit expanded as his business grew and peaked out over the last two or three years, and he's not needed additional financing. His business is such that he's practically reduced the loan with us to nothing."

To Robin, however, the financial rewards appear to take a back seat to simply having a good time.

"We're a very flexible operation," Robin said. "We're nice to people—unless something happens. Then we lay down the law. But you've heard the saying: 'You can get more with sugar than with vinegar.' "

Because of their long-time familiarity with the wholesale/retail garment business, Robin and Fox said they are able to jump on fads and offer high-demand items to clothing and specialty stores.

They said they did a good business last year with the popular long, knotted, open-knit scarves. This year, they said, they're making similar gains in terry cloth sportswear.

"We're an 'item house.' If something gets good overnight we'll get into it," Fox explained. "That's what we're doing in terry cloth now.

"Look at this dress," he said as he pulled it off a warehouse rack. "A year ago somebody would have thought a terry cloth dress was a bathrobe. But it's 'hot' now. So we'll change whenever the market calls for it."

Robin said he was able to get into the business in 1969 because he recognized a strong market for women's scarves. He recalled he started by buying a "couple hundred dozen" scarves. One of his first orders was for $36,000.

"That account was paid in 10 days," Robin said. "I made a $15,000 to $14,000 profit to start off with. It was a case of being in the right place at the right time."

Robin and Fox expressed amazement at the apparent resistance of their business to the effects of inflation.

"Today merchandise is so blind," Robin said. "No one knows the difference any more (between price and value)."

Robin and Fox suggested that consumers try to be smart shoppers, looking beyond labels (which stores often sew in instead of retaining the manufacturer's) and analyzing the quality of the apparel. Shoppers can sometimes find the same item in so-called discount stores and fashionable stores, Robin said.

Robin said he hopes to see quite a few more fads come and go. He doesn't have any plans to quit.

"I'll stay here as long as the guy upstairs lets me," he said, at the same time joking that Fox works him too hard. "I can hardly wait til morning to get up and get down here. I love every minute of it."

But does he regret that he waited until so late in life to strike out on his own?

"Not for a minute. I've never regretted a thing."

John Switzer/staff

"I can hardly wait 'til morning to get down here. I love every minute of it."

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